REPORT OF THE
JOINT LEGISLATIVE AUDIT
AND REVIEW COMMISSION

SERVICES FOR MENTALLY DISABLED RESIDENTS OF ADULT CARE RESIDENCES

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Preface

SJR 96 and HJR 86 of the 1996 General Assembly directed JLARC to complete a follow-up review of a 1990 report by assessing the adequacy of mental health services for residents of adult care residences, formerly called homes for adults, and by identifying the best methods for providing such services. JLARC was also directed to examine funding for mental health services in adult care residences.

In the 1990 report, JLARC found that the basic health and safety of residents had improved over time, but that the needs of residents with mental health needs were not adequately served. With the current review, JLARC has found that the State continues to make progress in improving its ability to promote appropriate care in adult care residences. Implementation of recommendations from the 1990 report to recognize and fund different levels of care now provides for enhanced funding for those residents requiring more care at greater expense. In addition, implementation of the Uniform Assessment Instrument to assess residents' needs provides for the first time an important source of information about public pay residents.

While such progress is commendable, additional action is needed to ensure that adult care residences are a cost effective, appropriate placement for residents with mental disabilities. Among the most important of the improvements needed are better administration of medications, enhanced supervision of residents, stronger links between adult care residences and community services boards, and stronger enforcement of licensing requirements by the Department of Social Services.

It is also clear from this review that adult care residences can provide high quality services to mentally disabled residents. JLARC identified a number of model programs that are making available to residents a broad array of treatment and other services. Typically these adult care residences have links to services in the community and use sources of funding to supplement the auxiliary grant. While costs are higher in these model programs, their costs remain well below the costs of other residential treatment programs such as the State mental health facilities. If the Commonwealth wants to improve services generally to mentally disabled residents of adult care residences, it can look to these model programs for approaches that have proven effective. The State should also expect to provide additional funding for such services.

On behalf of the Commission staff, I would like to express our appreciation for the assistance and cooperation provided during this review by the staffs of the Department of Social Services, the Department of Medical Assistance Services, and community services boards, as well as the operators and staff of adult care residences.

Philip A. Leone
Director

July 25, 1997

JLARC Report Summary

Services for Mentally Disabled Residents of Adult Care Residences

July 1997

Joint Legislative Audit and Review Commission

The 1996 General Assembly passed two resolutions directing the Joint Legislative Audit and Review Commission (JLARC) to examine and recommend the best methods for providing mental health, mental retardation, and substance abuse services to persons residing in adult care residences. As part of the review, JLARC was also directed to make recommendations about funding services for these residents. The mandate for this study was thus focused on services to mentally disabled residents of adult care residences (ACRs).

JLARC has conducted two previous studies of adult care residences, formerly known as homes for adults. A 1979 evaluation addressed issues related to the health and safety of residents, and identified significant deficiencies. A 1990 follow-up study found that the basic health and safety measures to protect residents appeared to have improved in the homes, although JLARC found that the regulatory framework did not adequately protect residents with serious mental health or medical needs.

The current study takes place against a background of recent and substantial change in Virginia's ACR industry. Many of these changes address key concerns of the prior JLARC reports.

- Major legislation established two levels of licensed care in which ACR residents were to be placed, required that placements be based on assessments conducted by outside parties, mandated involvement by the Department of Medical Assistance Services in funding services for ACR residents, and directed that ACRs have adequate and sufficient staff to provide the care determined by the assessments.

- Revised and expanded ACR regulations took effect in February 1996. All ACRs were subsequently inspected for compliance with the new standards.

- A higher funding level for ACRs of $695 per month per resident took effect in 1996; funding for two higher levels of care — regular assisted living and intensive assisted living — was implemented in August 1996.

- Uniform assessment instruments, required for all auxiliary grant recipients, were completed in 1996. Data from these instruments provide, for the first time, statewide information about many ACR residents.

The combined effect of these recent State actions is helping move ACRs beyond providing just board and care, as was sometimes the case in the past. Some ACRs are model service providers, and are cost-effective alternatives to other more costly forms of residential care for the mentally disabled (see table below). As the ACR system moves toward providing services for residents with more complex medical and mental health needs, further steps need to be taken to improve services, standards, enforcement, and payment mechanisms.

Assessing ACR Residents' Needs for Services Has Been Improved

There are 612 ACRs licensed in the Commonwealth, with 27,537 beds. Statewide information about residents' needs has not been available in the past. Legislation adopted in 1993 established a process for assessing the needs of auxiliary grant recipients for services, and for ensuring that the individual's needs can be met by an ACR. All auxiliary grant recipients and private pay residents of ACRs were assessed using the Uniform Assessment Instrument (UAI) in 1996. The table on the following page shows that most auxiliary grant recipients require the residential living level of care, and almost a third require assisted living.

The uniform assessment instrument is limited in its effectiveness in assessing the needs of the mentally disabled. Therefore, refinements to the instrument are necessary to better assess the needs of this population. In addition, data from the UAIs should be analyzed in a timely manner. Summary information could be a valuable tool in tailoring local programs to the needs of ACR residents. One local agency analyzed UAI data for it's catchment area and made changes in services and staff. Not all localities have the data to do such a review, however.

Recommendation. *DMAS should more fully utilize UAI data by summarizing, analyzing, and sharing it with local agencies and other service providers. The criteria for distinguishing which level of care a mentally disabled resident needs should be reconsidered.*

ACRs and CSBs Could Better Serve Residents with Mental Health Needs

In 1996, an average of 6,950 ACR residents received auxiliary grants from the State to assist in paying for their care in ACRs. Based on assessments completed

Adult Care Residences Are a Cost-Effective Alternative

	Per Diem	Monthly	Annual
ACRs:			
Residential	$22.85	$695	$8,340
Assisted living	$25.82	$785	$9,420
Intensive assisted living	$28.78	$875	$10,500
Free-standing nursing facilities	$61.99	$1,885	$22,626
Hospital-based nursing facilities	$63.85	$1,885	$23,316
State facilities for the mentally retarded	$203.40	$6,187	$74,241
State facilities for the mentally ill	$267.59	$8,139	$97,670

How Auxiliary Grant Recipients Were Assessed by Level of Care

	Number of Residents	Percentage of Total
Residential Living	2,743	57%
Regular Assisted Living	1,413	29%
Intensive Assisted Living	656	14%
Total Assessments	4,812	100%

in 1996, 47 percent of these public pay ACR residents have been diagnosed with a mental disability. The sizable proportion of ACR residents with mental disabilities presents diverse challenges to ACR staff and to the community services supporting them.

Discharged Patients. State mental institutions have discharged significant, although declining, numbers of patients to ACRs in recent years. Community services boards (CSBs) assign case managers to oversee the placement of discharged patients who qualify for public funding. However, discharged residents cannot always be assured that ACRs will be able to meet their needs. Of CSB case managers surveyed by JLARC, 49 percent indicated that residents were being placed wherever there was a bed instead of matching their needs with an appropriate ACR. Seventy-one percent of the case managers indicated that ACRs did not provide their clients with the opportunity to achieve their highest level of functioning, a goal set in the *Code of Virginia*. Improved services, consistent monitoring of placements, and better communication between CSBs and ACRs are needed.

Individual Service Plans. Under DSS licensing standards, an ACR must develop an individualized service plan within 45 days of receiving a discharged patient. The plan is to spell out the individual's needs, the services to be provided, and the expected outcome. During site visits, JLARC staff found that service plans were rarely individualized, often reflecting minimal effort. A majority of the plans reviewed by JLARC contained only basic information about the residents, such as whether assistance was needed with specific tasks, without specifying how the ACR planned to meet the needs.

Recommendation. *In order to coordinate care between adult care residences and community services boards, the General Assembly may wish to amend the* Code of Virginia *to require community services board case managers to participate with adult care residences in the development and updating of individualized service plans. Community services board staff should also participate with the Department of Social Services licensing staff to provide training on the development and implementation of service plans.*

Medication Administration. The stability of many mentally ill persons, and avoidance of serious side effects, depends on proper management of multiple medications. ACR residents who are also auxiliary grant recipients take an average of seven prescription medications, according to Medicaid data. Some medications require weekly bloodwork and monitoring of behavior in order to prevent serious side effects. During the course of this review, problems at ACRs were identified, such as a lack of basic knowledge about medication management, improper administration of medications, failure to follow the protocol attendant with certain medications, and lack of adequate documentation. DSS standards require that all staff responsible for medication administration be certified by the Commonwealth to administer medication. However, JLARC staff found cases in which only one staff person at an ACR was trained and

certified in medication administration. It is impossible for that one person to be available at all times, so medications may be dispensed by individuals without proper certification, potentially endangering the residents.

Recommendation. *The Department of Social Services licensing requirements should provide for more than one staff person at an adult care residence to be trained in medication administration or require the ACR to enter into a contractual arrangement with a certified service provider to ensure that all medication is dispensed by individuals certified in medication administration. DSS should also consider improper administration of medications and inadequate monitoring of medications to be a serious violation of health and safety standards, and may want to impose financial penalties.*

Behavior Monitoring and Supervision. Supervision and assistance are key features distinguishing ACRs from independent living, but questionable levels of supervision persist in some facilities. During site visits to 35 ACRs, JLARC staff found supervision to be lacking in 11. Compliance with standards is not readily apparent when an ACR does not provide sufficient supervisory staff to know where residents are, or when non-supervisory personnel such as cooks or janitorial staff are also expected to monitor residents' behavior.

Recommendation. *DSS standards for ACRs should include a requirement for direct care ACR staff to receive training in the behavioral symptoms of mental disabilities and how to effectively monitor behavior of individuals with such disabilities. CSBs should routinely provide such training. DSS should consider the use of immediate financial penalties to enforce standards related to supervision of ACR residents.*

CSBs' Emergency Mental Health Services. Problems in accessing emergency mental health services may leave some clients unserved at critical times. The JLARC survey of ACR administrators found a majority indicating difficulty in accessing these services, which sometimes leads to dangerous situations for ACR staff and residents. The difficulties are due in part to a difference between what ACR staff typically mean by emergency services and the definition which is codified and utilized by CSB staff. Difficulties are also due to differences of opinion between ACRs and CSBs about whether a resident is having a mental health crisis or is simply exhibiting behavioral symptoms of a mental illness. Closer cooperation between CSBs and ACRs is needed, as well as additional training of ACR staff by CSBs.

Recommendation. *CSBs should be adequately staffed to provide emergency services. CSBs should be required to provide emergency services in ACRs, not just at the CSB office. CSBs should provide training to ACR staff on the legal parameters of emergency services and how to manage emergency situations.*

CSBs' Case Management Services. CSB staff who serve as case managers provide a variety of assistance to mentally disabled individuals and their families. They perform many services for their clients, and are often an essential connector between the client and the services and resources of the CSB and community. However, CSB case managers may not always visit their ACR clients due to heavy caseloads or because ACRs refuse to allow them access. In the JLARC survey of CSB case managers, 22 percent indicated they were unable to spend adequate time with their clients who resided in ACRs.

Recommendation. *ACRs which accept auxiliary grant recipients should be required to allow CSB case managers into their facilities to assist residents. CSBs should ensure that their case managers actually spend adequate time with the clients.*

Substance Abuse Services. Although some form of substance abuse services are available statewide from all CSBs, 20 percent of the ACR administrators responding to a JLARC survey indicated that such services are rarely or never available to their residents through the CSB. This is particularly troublesome because many ACRs are in locations that make it easy for residents to have access to drugs and alcohol.

Although some ACRs indicated that they specialize in serving the substance abuse population, this does not always reflect treatment expertise, but instead reflects that a majority of the ACRs' population has that particular diagnosis.

Recommendation. *DSS and DMHMRSAS should consider developing staffing and programming standards for ACRs which have significant populations of residents with histories of substance abuse. These should include staffing standards sufficient to limit residents' access to street drugs, a requirement that ACRs can accept persons with active substance abuse problems only if they are enrolled in a suitable treatment programs, and standards to require services be provided by the CSB or other qualified provider.*

Linkages Between ACRs and CSBs. Two CSBs have staff positions serving as liaison or consultant between the CSB and ACRs in the area. These positions regularly visit ACRs with mentally disabled clients, providing training and technical assistance to ACRs, and improving the overall coordination of services to clients. This practice appears to benefit clients in important ways, and should be replicated in other CSBs.

Recommendation. *The General Assembly may wish to consider providing sufficient funding for each CSB with a threshold number of clients residing in ACRs to have a staff position which focuses on ensuring service availability for clients, and on training and technical assistance to ACRs.*

Improved Enforcement Could Enhance Services for Residents

The 1996 licensing standards represent an improvement over prior standards in many ways. By distinguishing two levels of care, residential and assisted living, the new standards acknowledge the more intense care needs of some residents. The standards also implement a number of other previous JLARC recommendations. However, the standards still fall short of establishing an acceptable minimum level of care. The essential services provided by ACRs are supervision and assistance with personal care, which require staff. In most instances, the standards permit one staff member to be present regardless of the number of residents present or the level of care, so that one staff member in a very large ACR with an assisted living license would meet the requirement. This is inadequate for ACRs with numerous mentally disabled residents.

An assessment of the licensing standards found few differences between the services required for residents who need assisted living and the services required for persons at the residential living level of care. For example, there is no explicit requirement for routine help with the activities of daily living, although extensive effort has gone into assessing residents' needs for such assistance. The designation of some ACRs as providing assisted living, or as providing intensive assisted living, should reflect a significant difference in the amount of help provided to residents by ACR staff.

Recommendation. *The General Assembly may wish to provide statutory authority for a staffing standard. The DSS licensing standards for adult care residences should be revised to clearly link the number of staff required to be present to the level of service provided by the ACR, and to more clearly delineate the difference in services to residents between residential living, assisted living, and intensive assisted living.*

Stronger Enforcement of the Standards Is Needed

Although licensing standards have been improved in recent years, enforcement of the standards needs to be strengthened. In some cases, DSS permits ACRs to take too long to comply with standards. In part this is because DSS lacks a full range of sanctions to use to bring about compliance. It is also due in part to DSS's apparent reluctance to use sanctions already available. Currently, DSS may petition the courts to impose a civil penalty against any adult care residence. However, petitioning the courts may yield lengthy delays in action against violators. Through the use of a quasi-judicial process, as similarly implemented in other State agencies, DSS could impose expedient consequences for serious violations of the health, safety, welfare, and rights of residents. Financial consequences should be available as a tool to bring about compliance. Tying DMAS' supplemental payments to licensure status would also help strengthen enforcement.

Recommendation. *A stronger enforcement process should be established within DSS, with clear timelines for enforcement action to be taken. The General Assembly may wish to consider authorizing DSS to levy financial penalties as an additional means for obtaining compliance with the licensing standards. Consideration should also be given to establishing a priority list of basic standards pertaining to resident health and safety.*

Application of Practitioner Self-Referral Act

Statutes prohibit a health care practitioner from referring a patient for health services to any entity outside the practitioner's office or group if the practitioner or his or her immediate family is an investor in the entity. However, practitioners who make such referrals and are subsequently involved with the provision of care to the referred patient are exempted from this statute.

Concerns have been expressed by CSB staff and others about the referral practices of practitioners who also have financial interests in ACRs. If these practitioners were brought under the Practitioner Self Referral Act, they would be required to disclose their financial interest in any ACR to which they referred patients, and they would have to provide information to the patient about alternative placements.

Recommendation. *The General Assembly may wish to make the provisions of the Practitioner Self Referral Act applicable to physicians and psychiatrists who refer patients for care in an ACR in which they have a financial interest.*

A Team Approach to Licensing

As ACRs have accepted residents with higher care requirements, the knowledge, skills, and abilities required of ACR staff and of DSS licensing personnel have also increased. DSS licensing staff are not trained health care or mental health professionals. Involvement of experts from disciplines such as mental health, mental retardation, and aging can bring additional expertise to the ACR standards and inspection activities. By bringing additional outside perspectives to the matter of licensure, and by providing an additional source of expert technical assistance to both ACR staff and the DSS licensing function, a team approach to licensing could benefit residents.

Recommendation. *The General Assembly may wish to enhance ACR standards and regulation by identifying State agencies in addition to DSS which should develop modules of specific ACR standards, such as standards of care for mentally ill and mentally retarded residents. All ACRs would continue to be required to meet a set of core standards, and ACRs that wish to serve these specific populations would be required*

to meet standards developed specifically for those groups. Those same agencies should also be charged with determining compliance with those standards.

Best Methods of Serving Mentally Disabled ACR Residents

There appear to be several models of effective and efficient service provision to mentally ill, mentally retarded, and substance abuse residents. Some ACRs are able to provide service-rich environments by arranging for private service providers or hiring staff to meet the needs of mentally disabled residents. Many ACRs with significant numbers of these residents, however, depend on CSBs and other community services to provide psychiatric testing and treatment, as well as needed services and activities.

Factors which tend to distinguish the best ACRs include staff qualifications, employment of an activities director or coordinator, strong ties to community services and programs, strong links with the CSB, placement of residents in day programs outside the ACR, and access to additional funding. CSBs operate at least 17 ACRs, with a combination of funding from the auxiliary grant program, federal Home and Community Based Waiver funding, and other funding. The CSB-operated ACRs tend also to provide model services to residents.

As ACRs continue to evolve away from a board and care tradition toward serving a more diverse population with more complex medical and mental health needs, the State will need to strengthen licensing and enforcement, and consider ways to ensure that services and funding meet the residents' needs. There is also a need to recognize that model programs typically have significantly higher costs. A review of costs reported by several model programs indicated a median cost nearly double the basic auxiliary grant rate of $695 per month. Improved services may warrant increases in DMAS' supplemental payments. If such increases are supported by DMAS and the General Assembly, they should be tied to the provision of specific services for mentally disabled and other special need residents. Alternatively, direct funding could also be provided for such programs.

Rate Setting Process Is Unneeded

Virginia has two primary mechanisms to pay for care in an ACR. The auxiliary grant, which in combination with SSI totals a maximum of $695 per month, is intended to pay for a basic standard of living for the recipient. Beginning in February 1996, eligibility for an auxiliary grant was tied to an assessment of the need for residential care. As of August 1, 1996, additional payments of $90 and $180 per month for assisted living and intensive assisted living, respectively, were intended to provide for additional services to auxiliary grant recipients.

Monthly rates of payment under the auxiliary grant program are set through a process that requires ACRs to file cost reports with DSS. All but two of the more than 400 ACRs which applied for an auxiliary grant rate in 1995 were approved for the full monthly amount, so the cost reporting process and rate setting process has almost no effect on the auxiliary grant budget. Additionally, the cost reports are not necessarily based on audited cost information, and a review of reports filed in 1995 found numerous reporting errors. However, some financial data collection remains necessary.

Since the Department of Medical Assistance Services is currently responsible for the payment of assisted living services, DMAS performs audits to ensure the proper utilization of State and federal funds. In addition, without appropriate financial data DMAS would be unable to evaluate the costs of providing regular and intensive assisted living services. In contrast to the current rate setting function, DMAS would not require an annual data collection effort. How-

ever, should DMAS pursue regular collection of financial information from ACRs, steps should be taken to ensure the accuracy of the information.

Recommendation. *The General Assembly may wish to abolish the rate setting process used to set monthly auxiliary grant rates for individual adult care residences. Instead, rates should be set through the State budget process. DMAS should collect appropriate financial data for prospective rate setting for assisted living services, and take steps to improve the accuracy of financial information reported by ACRs.*

DMAS Supplemental Payments Should Be Tied to Licensure

The increments of $3 and $6 per day ($90 and $180 per month) paid for assisted living and intensive assisted living stem from the costs associated with providing a half-hour and hour, respectively, of personal care per day. These assumptions are not incorporated into DSS licensing standards, but instead are enforced through the Medicaid payment and utilization review process. This review process has been temporarily suspended, however, in order to speed payments to ACRs. When the process commences, it will be retroactive and funds will be recovered, according to DMAS, if it is found that services were not provided.

An ACR on a provisional license may receive the full auxiliary grant and DMAS assisted living payments, as may a facility with a three-year license with a record of full compliance. DMAS is currently seeking an Attorney General's opinion as to whether it has the authority to withhold or suspend funding to a provisional licensee. When DSS has sufficient concern about the care and conditions of an ACR to issue a provisional license, there should also be a financial consequence for the ACR.

Recommendation. *DSS licensing standards should reflect the need for additional personal assistance in the assisted living category of care. Consideration should also be given to identifying in the DSS standards an enhanced level of care which would correspond to the intensive assisted living level of payments provided by DMAS. The General Assembly may wish to consider authorizing DMAS to reduce, withhold, or suspend assisted living and intensive assisted living payments to ACRs with provisional licenses.*

The Personal Allowance Should Be Increased

Auxiliary grant recipients are allowed $40 per month to cover personal needs ranging from clothing, medical co-payments, dental and eye care, and transportation, to personal use items such as tobacco products. Licensing standards permit ACRs to use $10 of the resident's allowance for laundry, leaving $30 per month for all other costs. JLARC found that typically $7 of the remaining $30 must be spent on medication co-payments. The remaining $23 per month is inadequate to cover the remaining personal needs. If the personal allowance had kept up with inflation since the 1979 JLARC report, it would now be $54 per month.

Recommendation. *DMAS and DSS should explore the feasibility of developing a medical reimbursement account for auxiliary grant residents in ACRs. DMAS should report its findings to the 1998 session of the General Assembly. In addition, DSS should conduct a review of the typical costs incurred by ACR residents on a monthly basis, and recommend an adjustment to the personal allowance. The full amount of any increment should be provided for the personal use of the recipients.*

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I. Introduction

Adult care residences (ACRs), formerly known as homes for adults, provide maintenance and care for four or more adults who may have limited functional capabilities, including the aged, infirm, or disabled. They are typically operated by private providers, but receive funding from federal, State, and local sources. There are 612 ACRs licensed in Virginia, with 27,537 beds.

ACRs have been continuing objects of study and review for nearly two decades. Concerns have been raised about: (1) the health and safety of residents, (2) the effectiveness of adult care residence licensure and monitoring, (3) the adequacy of the auxiliary grants program, and (4) the appropriateness of an ACR setting for adults with mental disabilities.

Two prior reviews of adult homes have been conducted by the Joint Legislative Audit and Review Commission (JLARC). A 1979 report conducted an in-depth evaluation of the adult home system in Virginia and identified numerous problems. A follow-up report conducted by JLARC in 1990 found that basic health and safety measures to protect residents had improved, although the regulatory framework then in place did not adequately protect residents with serious mental health or medical needs.

House Joint Resolution 86 and Senate Joint Resolution 96 passed by the 1996 Session of the General Assembly (Appendix A) directed JLARC to examine and make recommendations regarding the best methods for providing mental health, mental retardation and substance abuse services to persons residing in adult care residences. As part of the review, JLARC was also directed to make recommendations for funding services for these residents.

The mandate for this study is focused therefore on services to residents with mental disabilities who reside in adult care residences. This chapter briefly describes recommendations of the earlier JLARC reports and actions taken in response to the recommendations. It also describes adult care residences and the State agencies involved in regulating and funding them. A discussion of the approach taken by JLARC staff in conducting this study is also included.

The remainder of this report discusses issues related to improvements in services for mentally disabled residents of ACRs, model programs for those residents, improvements in licensing and enforcement, and funding for ACR services. In recent years, there have been significant improvements in the regulation and funding of ACRs, but services for residents with special needs continue to be problematic. If the State wants to continue to use ACRs as a cost effective residential alternative to both State facility and community care of persons with mental illness and mental retardation, it will need to better provide for services to those residents. With improvements in basic health and safety, the State needs to turn now to improvements in mental health services for ACR residents.

PRIOR STUDIES AND RECENT LEGISLATION

In 1979, JLARC conducted an in-depth evaluation of the adult home system in Virginia. That report basically addressed issues related to the health and safety of residents. The report identified significant deficiencies in these areas.

In 1990, JLARC conducted a follow-up to the 1979 study. During the 1990 follow-up, JLARC staff revisited all of the homes still in operation which were selected for field visits in 1979. During these visits, JLARC staff observed that some of the conditions identified in 1979 were not evident in 1990. Serious problems with food service, nutrition, and sanitation were not observed in the homes visited in 1990. Although from 1979 to 1990 the basic health and safety measures to protect residents appeared to have improved in ACRs, JLARC found that the regulatory framework did not adequately protect residents who had serious mental health or medical needs.

Significant Actions Have Been Taken Since the 1990 JLARC Report

Since the 1990 JLARC report, a number of actions have been taken to implement the recommendations and to correct deficiencies. Exhibit 1 summarizes the major recommendations of JLARC's 1990 report and related actions taken.

The current study takes place against a background of recent and substantial change in Virginia's ACR industry. Many of these changes address the main concerns of the 1990 JLARC review.

- Major legislation was adopted by the 1993 General Assembly, identifying two levels of care in which ACR residents would be placed, and requiring that such determinations be based on assessments conducted by outside parties.

- Legislation adopted in 1995 directed that ACRs must have adequate and sufficient staff to provide the care determined by the assessments, and clarified who could perform the assessments.

- A major study was conducted by the Virginia Long-Term Care Council to determine the intensity of service needs in ACRs. This data provided the foundation for developing regulations and for establishing multiple licensed levels of care in ACRs.

- Revised and expanded ACR regulations took effect in February 1996. All ACRs were subsequently inspected for compliance with the new standards.

- A higher funding level ($695 per month per resident and $799 in Northern Virginia Planning District 8) took effect in 1996, with funding for two higher

Exhibit 1

Status of Major Recommendations from the 1990 JLARC Homes for Adults Study

Recommendations	Currently Implemented	Additional Action Necessary
Development of a client needs assessment instrument	✔	Yes
Development of adult home licensing standards for different levels of care	✔	Yes
ACR staff required to be literate	✔	No
Administrator education and experience requirements should be strengthened	○	Yes
Additional hours of training for special populations	○	Yes
DSS should promulgate staffing guidelines for use in enforcing licensing standards	✘	Yes
Staffing qualifications for additional levels of care	○	Yes
Staff qualifications to perform certain procedures	○	Yes
Additional standards for medication management: training; unit dose packaging; maintenance log; & notations when medications are dispensed	✔	Yes
Staff must be 18, physician's orders must be followed, clarify requirements related to food service	✔	No
Maintain consistent monitoring throughout regions	○	Yes
Annual unannounced licensing renewal inspections	○	Yes
Certified dietitian to review menus in licensed homes and special diets should receive particular scrutiny	✘	Yes
Allow DSS Commissioner to use intermediate sanctions, i.e., the reduction of licensed capacity	✔	Yes
Develop an effective cost reporting process and change cost reporting period, and revise cost reporting form	✘	Yes
Minimum monthly ACR rate should be adjusted	✔	No
Regulatory changes governing charges for AG residents, i.e., laundry, special diets, extra portions	✔	No
Increasing the personal allowance to AG recipients	✔	Yes
Link auxiliary grant funding to levels of care	✔	Yes

KEY: ✔ = Generally Implemented ○ = Partially Implemented ✘ = Not Implemented

Source: JLARC staff analysis of statutory and regulatory changes.

levels of care — bringing the maximum payment to $875 per month — starting in August 1996. Effective July 1997, the basic statewide rate will increase from $695 to $725.

- Uniform assessment instruments, required of all ACR residents to ensure continued placement in an ACR, were completed for the first time in 1996. Data from these instruments provide, for the first time, a reliable statewide description of ACR residents.

1993 Virginia Long-Term Care Council Study

In 1993, the Virginia Long-term Care Council issued a report, *An Examination of Intensity of Service Needs in Virginia's Adult Care Residences*. This study was the first comprehensive analysis of the characteristics and care needs of ACR residents in the Commonwealth. The study was also used to develop standards which specify levels of care in ACRs.

The report was based on a 1993 survey of 1,970 residents in more than 200 ACRs. The impetus for the study was legislation which instructed the Secretary of Health and Human Resources to analyze the intensity of service needs in Virginia's adult care residence population.

Using a sample of ACR residents and a draft of the recently developed Uniform Assessment Instrument (UAI), the Long-Term Care Council report analyzed the intensity of service needs. A key finding was that at least 23 percent, and perhaps as many as 43 percent, of all ACR residents had one or more mental disabilities and required assistance with some of the activities of daily living. According to the report, residents who required mental health, mental retardation, and substance abuse services comprised approximately 23 percent of the ACR population. In addition, the study found that about nine percent of the ACR population was diagnosed as mentally retarded. The report also noted that approximately four percent carried a diagnosis of a condition related to developmental disabilities.

The report found differences between auxiliary grant recipients, who receive State support to reside in an ACR, and other ACR residents. For example, 58 percent of auxiliary grant residents compared with 41 percent of other residents required assistance with the instrumental activities of daily living (IADLs).

The Virginia Long-term Care Council study found that 43 percent of auxiliary grant recipients had psychiatric conditions. About 13 percent of all residents were diagnosed as having a psychiatric condition. Almost all auxiliary grant recipients, 92 percent, required assistance with medication administration. In contrast, about 61 percent of other residents required assistance with medication administration.

Finally, the Virginia Long-term Care Council study estimated that approximately 15 percent of ACR residents would be eligible for assisted living services. This estimate was subsequently used in developing appropriations for the assisted living level of care.

Recent Legislation Established Levels of Care

During the 1993 and 1995 sessions, the Virginia General Assembly passed significant legislation affecting the adult care residence industry. The 1993 General Assembly enacted legislation which created two levels of care in licensed adult care residences: residential and assisted living. The key difference between the two levels is the amount of assistance an individual requires with the basic activities of daily living (ADLs).

The *Code of Virginia* was also amended in 1993 to require that all residents be evaluated to determine their need for residential care upon admission and at subsequent intervals. This legislation also required the ACR to provide assurances that it could meet the residents' documented needs. Requirements for case management services for public pay residents were included as well.

As a result of the changes required by statute, DSS developed three new sets of regulations. In addition to the standards for adult care residences, DSS developed standards for the auxiliary grant and assessment regulations. The new standards, which took more than two years to develop in compliance with the Administrative Process Act, took effect February 1, 1996. In addition, the Department of Medical Assistance Services promulgated regulations, which took effect at the same time, for the provision and payment of targeted case management services and assisted living services for auxiliary grant recipients who are residents of ACRs.

OVERVIEW OF ADULT CARE RESIDENCES

Adult care residences (ACRs), formerly known as homes for adults, provide maintenance and care for four or more adults who may have limited types or degrees of functional capabilities, including the aged, infirm, or disabled. ACRs have been regulated in Virginia since 1954.

Growth in the ACR Industry

ACRs have evolved from providing mainly board and care toward providing a broad range of services in support of residents. Some continue to provide small, home-like environments, while others are larger, sometimes in buildings converted from use as hospitals or hotels. A recent trend is large continuous care centers, which feature a

variety of living arrangements, typically ranging from independent living to an ACR to a nursing facility, all on the same premises.

The ACR industry has been characterized by growth in the number of facilities and in the number of beds available statewide. The number of ACRs has increased over the last 20 years, from 314 at the time of the 1979 JLARC study and 470 during the 1990 JLARC study to 612 in 1997. In 1979, the average size of these facilities was 31 beds; in 1997 the average size was 45 beds, about the same as in 1990. The smallest ACR has four beds; the largest more than 600 beds. Exhibit 2 provides a profile of adult care residences.

Exhibit 2

Profile of Adult Care Residences

- 612 adult care residences are licensed
- Range in size from 4 to 635 beds
- Average capacity is 45 beds
- 393 ACRs have a licensed capacity of 50 beds or less
- 54 ACRs have a licensed capacity of more than 100 beds
- 71% of ACRs have at least one Auxiliary Grant resident
- All residents of the facility receive an auxiliary grant in 35% of ACRs

Source: Department of Social Services

The total number of licensed beds in ACRs has increased from 10,420 in 1979, to 22,538 at the time of the 1990 JLARC study, to 27,537 in 1997. Table 1 shows the growth that has occurred since the 1979 JLARC report.

Table 1

The Number and Capacity of ACRs Is Increasing

	FY 1979	FY 1990	FY 1997
Number of ACRs	314	470	612
Licensed Beds	10,420	22,538	27,537
Residents (est.)	8,300	18,707-20,059	25,140
Auxiliary Grant Recipients	2,281	5,761	6,950*

*Number of auxiliary grant recipients for FY 1996.

Source: Follow-Up Review of Homes for Adults in Virginia, JLARC 1990; JLARC staff analysis of DSS Licensing Programs Division data; and JLARC survey of ACR administrators.

Several Public Agencies Are Involved with ACRs

Several State and local agencies have responsibilities for different aspects of ACRs. The Department of Social Services (DSS) licenses ACRs, including monitoring compliance with standards, ensuring all ACR residents are assessed using a standard assessment instrument, and funding the auxiliary grants program. The Department of Medical Assistance Services (DMAS) is responsible for making payments for certain specific services for auxiliary grant recipients, such as paying for assessments of individual residents, case management services, and assisted living and intensive assisted living services.

Community services boards (CSBs) provide case management services and psychiatric services, and frequently operate psychosocial rehabilitation and other programs for community residents with mental disabilities. These services and others are available to all residents of the CSBs' catchment areas, including ACR residents.

A variety of public agencies were involved in the first round of assessments using the Uniform Assessment Instrument (UAI), which began in 1996. In addition to local social services and community services boards, area agencies on aging, local health departments, and centers for independent living sent representatives into ACRs to administer UAIs. Other local agencies also have specific roles with ACRs. For example, local health department sanitarians inspect the food preparation areas of ACRs, and local fire inspectors determine compliance with the fire code.

Levels of Care in ACRs

The role of the ACR as care provider has evolved away from a board and care model of the traditional adult home toward that of serving persons with diverse medical needs and problems. The State has in effect encouraged the development of the ACR industry as a major, though unplanned, component of housing and treatment for persons with mental disabilities. ACRs are a major placement option for Virginia's State-operated mental health facilities. In FY 1996, for example, 508 or seven percent of all persons discharged from State facilities were placed in ACRs. In addition, State and local funding is only available to persons residing in ACRs. The State auxiliary grant combined with a resident's countable income is intended to cover the cost of room, board, and basic supervision while residing in an ACR.

JLARC's 1990 report pointed out that the ACR system had grown as a result of continued federal and State efforts to reduce the costs associated with Medicaid funded placements in nursing homes. This trend appears to be continuing. ACRs fill a gap between in-home care and nursing home care for many individuals.

The levels of care in ACRs, mandated by statute, allow these facilities to care for individuals with a wide variety of needs. ACRs are now licensed to provide two levels of care: residential and assisted living. To be eligible for any of the levels of care

in an ACR, public pay individuals must meet criteria described in the DSS and DMAS regulations and determined by an assessment using the UAI. To be licensed to provide assisted living services, an ACR must meet additional criteria above the basic residential living level of care. Exhibit 3 provides definitions of key terms used in describing adult care residences.

Residential Living. Residential living indicates a level of service for adults who may have physical or mental impairments and require only minimal assistance with the activities of daily living (ADLs). Included in this level of service are individuals who are dependent on others for medication administration. Individuals meet the criteria for residential living when they are rated, through use of the UAI, as (1) dependent in only one of seven ADLs (bathing, dressing, toileting, transferring (moving between the bed, chair, wheelchair, and/or stretcher), bowel function, bladder function, and eating/feeding), and (2) dependent in one or more of four selected IADLs (meal preparation, housekeeping, laundry, or money management) or (3) dependent in medication administration. ACRs which provide residential living services to auxiliary grant recipients may apply for an auxiliary grant rate of $695 per month. ACRs in Northern Virginia Planning District 8 are eligible for a higher rate of $799 per month.

Assisted Living. The Commonwealth has developed two levels of payment for additional personal care needs of public pay assisted living residents: (1) Regular assisted living services (a non-Medicaid program), for which an ACR may receive $90 per resident per month in addition to the auxiliary grant payment of $695 ($799 in Northern Virginia Planning District 8), and (2) intensive assisted living services, which is reimbursed under the Medicaid program at the rate of $180 per month in addition to the $695 auxiliary grant. In addition, as of July 1, 1997, the rate will increase to $725 per month.

Regular assisted living services means a level of service provided to persons who are dependent in two or more ADLs or dependent in behavior pattern. Included in this level of service are individuals who are dependent in behavior pattern, (i.e. abusive, aggressive, disruptive), as documented on the uniform assessment instrument.

Intensive assisted living services means services provided under the federal Social Security Act, Section 1915 (c) waiver program to persons who have dependencies in four or more ADLs, or who have a combination of dependencies in ADLs and cognitive or behavior problems. Table 2 shows the conditions and areas for which residents need assistance in the three levels of care.

Exhibit 3

Definitions of Key Terms

Adult Care Residence (ACR): Any place, establishment, or institution, whether public or private, operated or maintained for the maintenance or care of four or more adults who are aged, infirm, or disabled and who are cared for in a primarily residential setting, except (i) a facility or portion of a facility licensed by the State Board of Health or DMHMRSAS, but including any portion of such facility not so licensed, and (ii) the home or residence of an individual who cares for or maintains only persons related to him by blood or marriage, and (iii) a facility or any portion serving infirm or disabled persons between the ages of 18 and 21.... Included in this definition are any two or more places ... owned or operated by a single entity and providing maintenance or care to a combined total of four or more aged, infirm, or disabled adults.

Activities of Daily Living (ADLs): Seven basic activities of life: bathing, dressing, toileting, bowel function, bladder function, transferring (moving between the bed, chair, wheelchair, and/or stretcher), and eating/feeding. A person's degree of independence in performing these activities is a part of determining appropriate level of care and services.

Assisted Living: Services provided by an ACR for residents who may have physical or mental impairments and require at least moderate assistance with the activities of daily living. Moderate assistance means dependency in two or more activities of daily living. Included in this level of service are individuals who are dependent in behavior pattern (i.e., abusive, aggressive, disruptive) as documented on the uniform assessment instrument. There are two levels of assisted living for which DMAS will pay: "regular" assisted living, for which DMAS supplements the auxiliary grant with an additional $90 per month, and "intensive" assisted living, for which DMAS contributes a total of $180 per month over and above the auxiliary grant.

Auxiliary Grants Program: A state (80%) and locally (20%) funded financial assistance program, administered by DSS, to provide additional income for a Supplemental Security Income (SSI) recipient or adult who would be eligible for SSI except for excess income, who resides in an ACR with an approved rate. The maximum grant is $695 per month plus $40 personal allowance. In FY96, Virginia made $19.5 million in auxiliary grant payments to an average of 6,950 recipients. As of July 1, 1997 the grant rate will increase to $725 per month.

Case Management: Includes a variety of activities designed to link individuals to appropriate services. Case management may include the initial screening of need, comprehensive assessment of needs, development and implementation of a plan of care, service monitoring, and follow-up. "Targeted case management" means the provision of ongoing case management services typically by a Community Services Board employee to an auxiliary grant recipient of an ACR. Targeted case management is a Medicaid-reimbursable service.

Instrumental Activities of Daily Living (IADLs): Eight basic activities of life that require a higher level of cognitive functioning than the ADLs: meal preparation, housekeeping, laundry, money management, transportation, shopping, using the phone, and home maintenance. A person's degree of independence in performing these activities is a part of determining appropriate level of care and services.

Uniform Assessment Instrument (UAI): A written instrument, approved by DSS & DMAS, which provides basic descriptive and medical history information about an individual and documents an assessment of the individual's degree of independence in performing ADLs & IADLs. Under new standards, a UAI is completed for each auxiliary grant recipient residing in an ACR. A follow-up UAI is completed whenever there is a "change in condition" of the individual.

Sources: DSS and DMAS regulations and the Appropriation Act.

Table 2

Levels of Care: Resident's Functional Capacity

	Residential	Regular Assisted Living	Intensive Assisted Living
Monthly State Payment	$695	$785	$875
Dependent in Medication Administration	●	●	●
Dependent in only 1 ADL	●		
Dependent in 1 or more IADL	●		
Dependent in 2 or more ADLs		●	
Dependent in behavior pattern (abusive, aggressive)		●	
Dependent in 4 or more ADLs			●
Dependent in 2 or more ADLs and dependent or semi-dependent in a combination of behavior pattern and orientation			●
Semi-dependent in 2 or more ADLs or dependent in combination of behavior pattern and orientation			●

Source: JLARC staff analysis of DSS and DMAS regulations.

Funding of ACRs

Primary funding for public pay residents of ACRs is the auxiliary grant. It is an "auxiliary" payment in that it is an addition to the supplemental security income (SSI) payments made to the ACR residents. The auxiliary grant provides additional income for a Supplemental Security Income (SSI) recipient or an adult who would be eligible for SSI except for excess income, who resides in an ACR with an approved rate. The auxiliary grant rate sets the "floor" or minimum cost of care in adult care residences. The Appropriation Act specifies the auxiliary grant rate, which is $695 per month in FY 1997 and $725 per month in FY 1998. The grant rate is $799 per month in Planning District 8 which includes the cities of Alexandria, Fairfax, Falls Church,

Manassas, and Manassas Park. These total grant amounts include the SSI payment, the State and local supplement, and any non-exempt or countable income of the individual. Localities are responsible for 20 percent of the State supplement. The rates are set through the State budget process based on incremental increases to prior years' rates, and are not directly tied to the cost of providing room, board, and supervision as set out in the DSS regulations.

Many individuals, including discharged patients, could not afford to live in ACRs without the auxiliary grant. This funding stream has resulted in the continued development of ACRs across the state. In FY 1996, the Commonwealth spent more than $19.5 million supporting about 7,000 auxiliary grant recipients living in ACRs (Table 3). Additional public funding for ACR residents and services derives from Medicaid, general relief, community service boards, and local social services agencies.

Table 3

Auxiliary Grants Program Expenditures and Case Counts

Fiscal Year	Monthly Maximum Grant Rate[1]	Number of Recipients[2]	Average Monthly Grant[3]	Total Annual Expenditures
1990	$602	5761	$225	$15,527,136
1991	$616	5979	$227	$16,323,015
1992	$631	6236	$223	$16,657,067
1993	$631	6521	$220	$17,234,434
1994	$665	6739	$214	$17,339,974
1995	$675	7016	$229	$19,253,455
1996	$695	6950	$236	$19,540,942

[1] Excludes rate for Planning District Number 8.
[2] Average number of recipients per month.
[3] Average dollar amount of State and local funded auxiliary grant per month as a supplement to the SSI benefit, which includes the personal needs allowance of $40 per month.

Source: DSS.

An examination of Medicaid spending on services for auxiliary grant recipients shows that $7,781,705 was expended in 1996, the first year that Medicaid funding was available. Medicaid spending includes services provided by CSBs and by medical providers, as well as the assisted living supplements paid to ACRs. Because these supplemental payments began late in the year, however, the total for FY 1996 is likely to understate Medicaid spending that can be expected in subsequent years. Adding Medicaid and auxiliary grant expenditures for fiscal year 1996, the State and localities spent in excess of $27.3 million for the care of auxiliary grant recipients (Table 4).

Table 4

State and Local Expenditures on Services for ACR Residents

Auxiliary Grant (FY 1996)	$19,540,942
Medicaid (CY 1996)	$ 7,781,705
TOTAL	$27,322,647

Source: JLARC analysis of DSS and DMAS data.

The monthly auxiliary grant payment is significantly lower than the monthly cost of other State residential programs. Table 5 shows State expenditures for adult residential care in a variety of settings. The amount spent on ACRs through the auxiliary grant program is one of the lowest amounts paid by the State for any adult residential setting. On an hourly basis, ACRs are reimbursed at the rate of about $1.00 per hour. By contrast, Medicaid compensates personal care provided in an individual Medicaid recipient's personal home at the rate of $9.50 per hour. While such services are different, clearly the auxiliary grant funding for ACRs is much lower than the cost of care in State residential facilities for persons with mental illness. At this level of funding, ACRs may become a more cost effective alternative to State institutional care.

Table 5

Expenditures for Adult Residential Care FY 1997

	Per Diem	Monthly	Annual
ACRs:			
Residential	$22.85	$695	$8,340
Assisted living	$25.82	$785	$9,420
Intensive assisted living	$28.78	$875	$10,500
Free-standing nursing facilities	$61.99	$1,885	$22,626
Hospital-based nursing facilities	$63.85	$1,885	$23,316
State facilities for the mentally retarded	$203.40	$6,187	$74,241
State facilities for the mentally ill	$267.59	$8,139	$97,670

Source: JLARC analysis of data provided by DSS, DMAS, and DMHMRSAS.

STUDY APPROACH AND METHODS

The major issues addressed in this report are similar to issues identified in the prior JLARC reports, except that the current study has a narrower focus on services provided to the persons with mental illness, mental retardation, and substance abuse problems who reside in ACRs. The study mandate also focuses more narrowly on identifying the best methods of delivering services, along with the costs of doing so.

Taking into consideration the narrower focus on both residents and services, the objectives of this study were to:

- identify services required by and provided to this population,
- determine what assurances are in place that these services, especially those provided to public pay residents, meet basic expectations for quality, and
- determine whether payments by the State are adequate for the provision of quality services.

Target Population

The primary thrust of the current JLARC review focuses on public pay residents diagnosed with or who have a history of mental illness, mental retardation, and/or substance abuse. While all residents with a history of these problems are of concern, the State's interest is greatest in those residents whose care is paid for by public funds.

The 1993 report by the Virginia Long-Term Care Council found that residents who require services for these problems comprise approximately 23 percent of all ACR residents. The report also found that a larger percentage of the public pay residents requires such services. The Long-Term Care Council report estimated that about 40 percent, or 2,800 of the 7,000 public pay residents require mental health, mental retardation, or substance abuse services. Based on 1996 Uniform Assessment Instrument data, Table 6 compares the characteristics of all auxiliary grants residents to the target population of auxiliary grants residents with a mental illness or mental retardation diagnosis.

Principal Methods

This report addresses the issues through several methods, including: two surveys; analyses of data obtained from the Uniform Assessment Instrument, the Long Term Care Information System, and Medicaid history file; and on-site data collection from the case files of a sample of 21 ACR residents with mental disabilities. In addition, JLARC staff visited 35 ACRs, nine CSBs, and seven CSB-operated psychosocial rehabilitation programs during the course of the study. Numerous structured inter-

Table 6

Characteristics of Public Pay ACR Residents

	All UAI N=4812	Target Population N=1934
Sex		
Female	54%	51%
Male	47%	49%
Age		
Median Age	65	57
Oldest	107	103
Youngest	18	18
Race		
African American	34%	33%
Native American	0.2%	0.1%
Asian	0.4%	0.5%
Alaskan Native	0.1%	0.1%
Caucasian	65%	66%
Requires Assistance with ADLs		
Bathing	55%	63%
Dressing	33%	46%
Toileting	18%	20%
Transferring	14%	11%
Eating	9%	11%
Bowel Control	12%	13%
Bladder Control	20%	23%
Assistance with IADLs		
Meal Preparation	87%	92%
Housekeeping	83%	88%
Laundry	82%	87%
Money Management	85%	92%
Transportation	85%	91%
Shopping	79%	87%
Telephone	51%	63%
Home Maintenance	80%	96%
Assistance with Medications	80%	96%
Disoriented at least sometimes	33%	48%

Source: JLARC analysis of Uniform Assessment Instrument data.

views were conducted with State and local agency staff, ACR staff, residents, family members, and other interested parties.

Two surveys were used to collect information statewide. The first was administered to all CSB case managers and selected other staff (such as nurses) who had three or more clients residing in an ACR. Of 280 instruments distributed, 243 were returned for analysis, for a response rate of 87 percent. This instrument collected information about caseloads, conditions in ACRs, and services available to ACR residents. The survey was used to determine the types of and extent to which services are available to ACR residents. In addition, the survey responses were used to assess conditions in ACRs as they relate to the needs of residents with mental disabilities.

A second survey was administered to a randomly chosen sample of 397 adult care residence administrators. JLARC received 207 completed instruments from the administrators, for a response rate of 52 percent. This survey collected information relating to the general characteristics of ACRs, ACR staff, and ACR residents. In addition, the survey responses were used to evaluate the relationship between CSBs and ACRs, and to assess services provided to residents with mental disabilities in ACRs. The survey was also used to obtain information about the DSS licensing function.

Data used for this review included the Uniform Assessment Instruments administered to approximately 7,000 residents of Adult Care Residences in 1996. Collected by a variety of staff from Area Agencies on Aging, local departments of social services, community service boards, and others, this information was forwarded to the Department of Medical Assistance Services. The data were used to compile demographic information about the residents in ACRs. In addition, the data was analyzed to determine the diagnoses and service needs of residents in ACRs.

REPORT ORGANIZATION

This chapter has provided an overview of adult care residences in Virginia and the statutory framework within which they are licensed and funded. This chapter has also noted the effects of prior studies by both JLARC and the Virginia Long-term Care Council, defined the scope of the current project, and described the research activities used to address key issues of this study.

The next chapter assesses mental health services for residents with mental disabilities of ACRs and discusses certain aspects of the regulation of ACRs by the State. Chapter III discusses several model programs that demonstrate the provision of high quality services to residents with mental disabilities. Finally, Chapter IV addresses State funding that is provided to ACRs, including the new assisted living supplemental payments provided by DMAS.

II. Mental Health Services for Mentally Disabled Residents in Adult Care Residences

By law, adult care residences (ACRs) are responsible for providing room and board, maintenance and care, medication administration, social and recreational activities, general supervision for safety, and for securing health care and transportation. In addition, regulations require licensed ACRs to protect the physical and mental well-being of residents.

A significant proportion of ACR residents are mentally ill, mentally retarded, and post-hospitalized individuals. While there is no comparable information available on all ACR residents, the recently completed assessments of public pay residents provide a snapshot of their characteristics. Of the 4,812 assessments of public pay ACR residents made available to JLARC, about 47 percent had a mental health diagnosis. Table 7 indicates that schizophrenia is the most common mental health diagnosis among public pay ACR residents. The next most common diagnosis is mental retardation.

Table 7

Mental Health Diagnoses of Public Pay ACR Residents

Diagnosis	Percentage*
Schizophrenia	16.9%
Mental Retardation	11.1
Other Psychiatric	4.4
Bipolar and Personality Disorder	3.3
Major Depression	3.2
Non-Alzheimer's Dementia	2.8
Alzheimer's	2.0
Anxiety Disorders	1.4
Epilepsy and Other Neurological	1.4
Total	46.5%

*Based on 4,812 assessments.

Source: JLARC analysis of UAI data.

Prior reports, including JLARC's 1979 and 1990 studies of ACRs, noted deficiencies in assessing resident needs and providing care and services to residents with mental disabilities. Recently, licensing standards have been strengthened, overall conditions in facilities have improved, and some progress has been made in assessing resident needs and bettering care for residents with mental disabilities. Concerns

remain, however, about assessment of resident needs, placement and admission into ACRs, the effectiveness of case management and monitoring of placements, and linkages between State facilities, community services boards (CSBs), and ACRs. These concerns must be addressed if adult care residences are to be effective placements for residents with mental disabilities.

ASSESSING ACR RESIDENTS' NEEDS FOR SERVICES HAS BEEN IMPROVED

Prior studies of adult care residences lacked reliable information on the characteristics of residents living in these facilities. The Uniform Assessment Instrument (UAI) provides the first comprehensive data on the characteristics and needs of residents in ACRs and was completed on each of about 7,000 auxiliary grant recipients in 1996. The data captured in the UAI enables local service providers to determine the needs of ACR residents, and documents the level of services required by each resident. Previously, no information of this type was available.

Legislation adopted in 1993 authorized a UAI to be used to determine the need for publicly funded long-term care services across public health and human resource agencies. A written instrument developed by the Virginia Long-term Care Council, the UAI provides basic descriptive and medical history information about an individual and documents an assessment of the individual's degree of independence in performing the activities of daily living. Under DSS standards, a UAI is completed upon admission and at least every 12 months thereafter on each auxiliary grant recipient in an ACR. Another assessment is also to be completed whenever there is a "change in condition" of such individual that appears to warrant a change in the level of care.

Like many first-time efforts, administration of the UAI encountered operational difficulties, some of which remain unresolved. It is taking much longer than originally expected to compile all the information from the assessments, and the available information has not been fully analyzed. Overall, however, the UAI's initial use has provided much needed information about ACR residents with mental disabilities.

The Uniform Assessment Instrument (UAI)

The UAI meets several needs for information, such as helping ensure that an individual's placement in an ACR is appropriate, that the use of public funds is appropriate, and that the individual's needs can be met by the ACR. It also helps the ACR determine whether it can meet the needs of a prospective resident. According to one licensing specialist, the UAI "helps reduce the number of surprises as residents are placed in ACRs."

The UAI also helps ensure that an ACR placement is not an indefinite placement. As individuals age or their needs change, the UAI serves as a check on whether

the ACR can continue to meet the individual's needs. The outcome of the UAI for an individual should be either documentation of the need for care being provided in the person's current facility, or placement in a more appropriate level of care. Potentially, a resident could be moved from an ACR to a skilled nursing facility, if warranted by the UAI, or to independent living if it is found through the UAI process that the individual can manage accordingly.

The UAI as Placement Tool. The new levels of care in ACRs, mandated by legislation, allow these facilities to care for individuals with a wide variety of needs. ACRs now provide three levels of care: residential, regular assisted, and intensive assisted living. To be eligible for any of the levels of care in an ACR, public pay individuals must meet criteria outlined in DSS regulations and applied using the Uniform Assessment Instrument.

All new applicants to ACRs, regardless of payment status, will be assessed prior to admission and all current residents will be reassessed at least every 12 months or whenever there is a change in condition that appears to warrant a change in level of care. Initial admissions for services in an ACR must be assessed and authorized by an assessor, who, for public pay individuals, may be a case manager employed by a public human services agency or other qualified assessors who have a contract with DMAS to complete the assessment for applicants for residents of ACRs.

While a key purpose for the UAI was to better inform those making placement decisions, which could potentially have led to relocating residents from ACRs into other settings, JLARC staff identified very few instances in which this outcome had occurred. From interviews with CSB case managers and with ACR administrators, JLARC staff learned of only a few residents that had been moved due to their assessment. None of the 21 sampled individuals chosen for review in this study had been moved on the basis of the results of their UAI.

The UAI as Guide to Levels of Care. Another key purpose for the UAI was to place ACR residents in the most appropriate level of care – residential, regular assisted living, or intensive assisted living. The care and supervision provided by the ACR is expected to increase at the two higher levels. Payments for care also increases with each level, from $695 per month for residential living services, to $875 per month for intensive assisted living services.

During the course of this review, JLARC staff identified concerns that the UAI does not adequately measure mental deterioration, which can be key in determining care needs. Through the instrument's focus on the activities of daily living and residents' behavior, it misses aspects of mental illness and mental retardation. A CSB nurse noted,

> The UAI does not really capture the dependency of the client. For example, it asks you to score a client on a scale that ranges from "wandering" to "violent," which is a very wide range of behavior. Where do you place mentally retarded patients on this range?

The following question is used on the UAI to gauge behavior pattern:

> Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) or become agitated and abusive?
>
> Possible responses include:
>
> • appropriate behavior,
> • wandering/passive less than weekly
> • wandering/passive weekly or more
> • abusive/aggressive/disruptive less than weekly
> • abusive/aggressive/ disruptive weekly or more, and
> • comatose.

This question tries to indicate behavioral problems that can be difficult to manage in an ACR, without necessarily identifying the nature of the underlying condition of the resident. There may be numerous inappropriate behaviors regularly exhibited by an individual, and even if noted on the UAI, this data was not keyed into the Long Term Care Information System, and remains unknown.

In interviews, some CSB staff expressed concerns about the UAI inadequately measuring a patient's mental disability. Staff from several CSBs stated that measuring the ability to perform the activities of daily living (ADLs) does not effectively indicate the level of supervision required by persons with mental illness. Individuals with mental illness tend to have more difficulty with the instrumental activities of daily living (IADLs), such as managing money or preparing meals, than with ADLs. This tendency is clear in the JLARC sample of 21 individuals with mental disabilities, which had more difficulty with IADLs than ADLs. Few sample residents did not require assistance with all of their IADLs. In contrast, the majority of the sample did not require assistance with the performance of ADLs.

The UAI is not designed to be a diagnostic tool, but instead is intended for use as a screening and evaluation tool. Since July 1, 1994, most publicly funded human service agencies in Virginia have been using the UAI to gather information for the determination of an individual's care needs, for service eligibility, and for planning and monitoring client care needs across agencies and services. While the usefulness of the UAI as a placement tool for individuals with mental disabilities is limited, and specific items such as the question on behavior may need strengthening, a greater concern focuses on how the UAI was administered in 1996.

Administration of the UAI

Legislation in 1993 requested the Secretary of Health and Human Resources to develop and implement a uniform assessment instrument for use in all public health and human resource agencies in the Commonwealth. The UAI in its current form was based on a previously existing instrument which had been revised and further devel-

oped between 1993 and 1995, requiring the assistance of numerous State and local agencies.

Under the legislation and regulations subsequently adopted, Medicaid reimburses local agencies for assessments completed on current and prospective residents of ACRs. For a full UAI completed on an individual who qualifies for assisted living, the local agency is reimbursed at the rate of $100. A shortened version of the UAI, completed on all persons who require residential living, is reimbursed at the rate of $25.

Uniform Assessment Instruments were completed by staff of a number of local human services agencies, including: local area agencies on aging, community services boards, and local departments of social services. Completed instruments were then returned to DMAS by these local agencies for data entry and screening for accuracy. Initial UAIs were originally scheduled for completion by August 1, 1996. However, as of January 1997, many assessments were not complete. At least 1,600, or 23 percent of all UAIs which had been received by DMAS, had to be returned to assessors for clarification or corrections.

To facilitate entry of the UAI information, DMAS staff entered the components of the UAI which coincided with fields already available in the Long-Term Care Information System (LTCIS) maintained by DMAS. DMAS provided data to JLARC from the 5,410 completed UAIs which had been entered into the LTCIS as of January 16, 1997. Of that number, there were 527 data records for individuals who were not ACR residents, and 71 duplicate assessments, providing an effective sample size of 4,812 ACR residents for this study.

Table 8 displays the percentages of ACR residents assessed at each of the three levels of care. Of the assessments completed, 57 percent indicated the need for residential living, 29 percent indicated a need for regular assisted living, and 14 percent indicated that intensive assisted living was appropriate.

Table 8

ACR Assessments[1]

	Number of Residents	Percentage of Total
Residential Living	2,743	57%
Regular Assisted Living	1,413	29
Intensive Assisted Living	656	14
Total Assessments	4,812	100%

[1] Reflects UAI and Long Term Care Information System database as of January, 1997.

Source: JLARC staff analysis of Long Term Care Information System data.

Outcomes of the UAI. The UAI provides much information that is useful to both State and local agencies as well as to service providers such as ACRs. The accuracy of some of the assessments has been called into question, however, and DMAS should share the data with agencies which provide services to the ACR clients.

The 1996 effort to assess all 7,000 auxiliary grant recipients between February and August was a major undertaking. The assessments themselves were conducted by staff from a number of agencies, including CSBs, area agencies on aging, and local health and social services departments. Staff from these agencies who administered UAIs did so in addition to their normal caseloads and work assignments. They were trained in the UAI by DMAS through training sessions around the Commonwealth. Some other agencies, such as DSS, also held training sessions on the UAI for their staff.

At present, the UAI data is used primarily to determine the level of care required by ACR residents and to determine the amount of the DMAS supplemental payment to the ACR. Information compiled through the UAI process can have many additional uses, however. As an example,

> *One CSB completed almost 900 UAIs and analyzed the resulting information. As a result of this analysis, the CSB director determined that an additional psychosocial rehabilitation program or clubhouse was needed in the locality. The director also determined that additional case managers would be hired to meet the needs identified.*

By contrast, many CSBs only conducted UAIs for individuals already in their caseloads. As a result, these CSBs lacked the data to identify underserved individuals in their catchment areas. DMAS, which is the repository for the UAI data, should provide reports or summaries of UAI data to the local agencies which participated in the UAI process. Summary information from the UAI database could provide a valuable tool in helping tailor local programs and staffing levels.

Recommendation (1). **The Department of Medical Assistance services should more fully utilize Uniform Assessment Instrument data by summarizing, analyzing, and sharing it with the local agencies which helped collect it, and with other service providers.**

Limitations of the Uniform Assessment Instrument (UAI). While the UAI provides much more information about ACR residents than has previously been available, staff at DMHMRSAS have suggested that there are limitations to its effectiveness in assessing the needs of individuals with mental disabilities. Using Uniform Assessment Instrument data, Table 9 compares the level of assistance required with ADLs to that required for IADLs for residents with mental disabilities.

Both ACR administrators and mental health advocates have expressed concern that individuals are being assessed as needing only residential services when their symptoms require more intensive supervision. Illustrative of this point is the finding that 57 percent of JLARC's sample of 21 residents had the maximum number

Table 9

Assistance Required by Public Pay ACR Residents with Mental Disabilities

Activity	Percentage Requiring Help with Activity N=1934
Activities of Daily Living	
Bathing Bathing	62.5%
Dressing	46.3
Toileting	20.4
Transferring	11.3
Eating/Self Feeding	10.8
Bowel Control	12.9
Bladder Control	22.6
Instrumental Activities of Daily Living	
Meal Preparation	91.5%
Housekeeping	87.5
Laundry	87.2
Money Management	92.0
Transportation	91.0
Shopping	86.8
Using Telephone	63.3
Home Maintenance	86.1

Source: DMAS Uniform Assessment Instrument data.

of functional independence needs, although 48 percent of the sample was assessed as requiring regular residential living.

JLARC staff were also informed of situations in which assessments were not conducted by individuals well-versed in the needs of persons with mental illness. In fact, staff from DMAS have suggested that with respect to assessments, DMHMRSAS should provide more technical support to DSS and DMAS. DMAS and DSS do not have expertise in the mental health field. Consequently, DMHMRSAS may need to provide training on how to properly assess individuals with mental illness.

Recommendation (2). **The Department of Mental Health, Mental Retardation, and Substance Abuse Services should provide additional training to local agency personnel on how to properly assess individuals with mental illness.**

Recommendation (3). **The Secretary of Health and Human Resources should establish an interagency task force to address the limitations of the Uniform Assessment Instrument as a tool for assessing the needs of individuals with mental disabilities. The task force should reconsider the criteria for levels of care for residents with mental disabilities. The task force should include, but not be limited to, staff from the Department of Mental Health, Mental Retardation, and Substance Abuse Services, community services boards, the Department of Medical Assistance Services, the Department of Social Services, the Department of Rehabilitative Services, area agencies on aging, and adult care residences.**

ACRs AND CSBs COULD BETTER SERVE RESIDENTS WITH MENTAL HEALTH NEEDS

The sizable proportion of residents with mental disabilities present diverse challenges to ACR staff and for the community services supporting them. Individuals with mental retardation tend to be stable in their mental condition, with needs that tend not to change significantly from day to day. The chronically mentally ill, on the other hand, may have periods when their mental health status is stable, they can perform most of the activities of daily living, and require only minimal supervision. At other times, they may experience acute psychiatric episodes necessitating a more restrictive environment in which crisis stabilization can be provided. In addition, individuals with chronic mental illness tend to have other conditions due to their illness which are caused by stress, lack of sleep, and other symptoms. According to mental health professionals, these individuals often cycle in and out of wellness.

According to JLARC's survey of CSB case managers with clients in ACRs, key services related to mental disabilities which are provided by ACR staff include medication management, behavior and symptom monitoring, and supportive counseling. Many case managers noted, however, that these services were often performed poorly or erratically. CSB staff in several areas noted that: "ACRs tend to be mini-warehouses, where State hospitals are the big warehouses." A number of CSB staff noted that the most reliable contribution by ACRs was transportation to services provided by the CSB. The mother of an individual with mental illness told JLARC staff that:

> ACRs are not all alike. They are not necessarily bad places to be. They are sometimes the only places available where a person who cannot function independently can get their basic needs met.

In order to assess ACR services for residents with mental illness, mental retardation, and substance abuse needs, JLARC randomly selected 21 auxiliary grant recipients with a diagnosis reported on their Uniform Assessment Instrument (UAI) of mental illness or mental retardation. JLARC staff visited the ACRs where the 21 individuals reside, and where applicable, the clubhouse, sheltered workshop, or community services board in which they are served. Many of the sampled residents had

multiple medical and psychiatric conditions. In addition, more that 240 case managers working in CSBs were surveyed to assess the quality of services provided to ACR residents. Interviews were conducted with ACR administrators and staff, licensing specialists, and residents' families.

Required Mental Health Services in ACRs

Services in ACRs required by standards vary based upon the level of care the ACR is licensed to provide. All ACRs are required to provide some general services, such as trying to keep residents active, encouraging residents to achieve independence in the activities of daily living, and assisting residents in adjusting to their disabilities.

Additional Requirements for the Mentally Disabled. The standards promulgated by the Department of Social Services (DSS) which became effective in February, 1996, contained additional requirements for assisted living facilities caring for adults with mental illness, mental retardation, or who are substance abusers. New requirements included:

- a current psychiatric evaluation on admittance for residents with mental illness and mental retardation,
- securing services from and entering into a written agreement with a community services board, mental health clinic, or other mental health service provider,
- obtaining semi-annual progress notes on residents, and
- assisting residents in obtaining the services recommended in the initial evaluation and the progress notes.

Though the standards require ACRs to establish a relationship with a mental health provider, the standards do not fully address or provide for the identified needs of the residents with mental disabilities within the facility. For example, the establishment of a desired staffing ratio or requirement within the facilities is absent in the standards.

The additional requirements for mental health services occur only in the assisted and intensive assisted living levels of care. Yet, many individuals with mental disabilities are not assessed at those higher levels of care. In fact, based on the UAI data, 35 percent of the individuals with a mental health, mental retardation or substance abuse diagnosis were assessed as requiring only the residential living level of care. As a result, many persons with mental disabilities may remain underserved.

Increased Standards for Dementia. Requirements in the standards are more significant for ACRs with residents who have dementia (certain small ACRs are exempted from these requirements). Dementia is a memory impairment associated

with problems in abstract thinking, problems with judgment, other disturbances of brain function, and changes in personality. The disturbance is often severe enough to interfere significantly with the ability to perform routine activities.

These standards require at least two direct care staff members trained in the needs of residents with dementia to be on duty at all times residents are present. In addition, security monitoring is required on all outside doors, protective devices on windows, and related precautions. Consideration should be given to expanding the application of this standard to all ACRs which house residents with mental disabilities.

Placement and Admission in ACRs

Individuals are referred to adult care residences from a variety of sources, including families, doctors, State mental health and mental retardation facilities, local social service agencies, and local community services boards (CSBs). Over the last several years, State facilities have discharged a significant, although declining, number of patients to ACRs, as shown in Table 10. Despite discharge and placement policies, residents are not always assured that ACRs will be able to meet their needs. In addition, sufficient linkages between State facilities, CSBs, and ACRs are often not established.

Table 10

Discharges trom DMHMRSAS Facilities to ACRs

FY	Discharges to ACRs
1992	773
1993	610
1994	556
1995	576
1996	508
Total	3,023

Source: DMHMRSAS.

Adjusting to an ACR Placement. Residents with mental disabilities need assistance adjusting to a community setting, especially when they have lived for long periods of time in State facilities. According to CSB case managers as well as ACR administrators, persons transferred from State facilities often lack necessary living skills, such as cooking, personal hygiene, and money management. When such individuals are placed in ACRs, both CSB staff and licensing staff have stated that it can be very traumatic for the individuals. CSB emergency services workers indicated that it is common to receive multiple calls for crisis services for individuals newly placed in ACRs. To ease this period of adjustment, CSB and DSS staff suggest increasing the

duration of transition wherein an individual can spend gradually increasing amounts of time in an ACR, before permanent placement.

Many referrals are made without benefit of a pre-placement visit. CSB staff and DSS staff indicated that involving the individual in the selection process decreases the amount of transfer trauma and the need for emergency services. In response, one CSB instituted a pre-placement visit policy for all referrals. Potential residents must visit facilities before being permanently admitted. If residents do not like the home, they can return to their previous residence. Staff at this CSB indicated that the element of choice facilitates greater stability in placements.

DMHMRSAS Placement Policy. According to DMHMRSAS's policy concerning the placement of patients and residents in ACRs, discharge planning is to be conducted jointly by CSBs and State facilities to manage a patient's transition from hospital to community in an effective manner. Under this policy, the Department returns patients to the community once they no longer require the active treatment or training services that are provided by the Department's mental health and mental retardation treatment facilities.

Under the policy, determination of placement is to be based upon the individual's assessed needs and preferences, the level of care required, and the ability of the designated ACR to provide the necessary supports. In the case of individuals with primary or secondary substance abuse disorders, discharge placement should consider the patient's need for ongoing treatment and community supports based on the severity of the addictive disorder. The placement policy further requires a discharge plan to be developed jointly between the State facility and the CSB, once an individual is placed in an ACR. The plan is to be based on the individual's physical and psychosocial needs and should identify the service needs in a community setting.

Despite this policy, 49 percent of CSB case managers surveyed indicated that residents were being placed wherever a bed was available instead of having their needs matched with an appropriate ACR. Thirty-eight percent of CSB case managers indicated that adequate communications had not been established between State facilities, CSBs, and ACRs. According to one DSS licensing employee,

> Mental Health has to do more for their people than complain about ACR conditions to DSS. Many of these residents come from the mental health system. Once they are placed in an ACR, Mental Health drops the ball. To some extent, DMHMRSAS's official involvement ends at the time of discharge.

DMHMRSAS policy requires CSBs to regularly assess the appropriateness of placements in ACRs of persons who are actively receiving services from a CSB. When evaluating the appropriateness of placement, CSBs are directed to consider the individual's potential for living independently, for performing meaningful work, for participating in education and the community, and for opportunities for personal relationships.

Despite these directives for assessing a placement, 71 percent of case managers surveyed indicated that ACRs did not provide their clients with the opportunity to achieve their highest level of functioning, a goal set out in the *Code of Virginia*. The extent of this consensus among case managers raises a serious question about the public mental health agencies' and ACRs' abilities to meet the needs of the ACR population with mental disabilities. Practices such as placing residents wherever a bed can be found appears to be contrary to DMHMRSAS's policy, and may represent a violation of the licensing standards. Improved services, consistent monitoring of placements, and better communication between CSBs and ACRs are needed.

Licensing Standards for Placements. ACR licensing standards, promulgated by DSS, require that a resident not be admitted unless the ACR can provide or secure appropriate care for that resident. A resident may not be admitted to a facility that lacks staff with appropriate skills to provide the level of care that the individual requires. An ACR can not admit a resident until a determination has been made that the ACR can meet the resident's needs. The ACR is supposed to make this determination based upon the UAI, a physical examination report, and an interview between the administrator or his designee and the resident and any personal representatives of the resident.

During interviews with DSS licensing staff, CSB staff, and ACR administrators, JLARC staff were told that many ACRs will accept any potential resident into their facility regardless of the individual's needs.

> *One ACR administrator explained that the census was low throughout the region, so she was seeking ways to fill empty beds. She said that she was under pressure from the owners to keep the facility at capacity, and was willing to accept any eligible residents to fill the beds.*

Both CSB and DSS licensing staff have stated that this practice leads to an increase in the need for emergency services and may endanger the well- being of other residents in the ACR when the facility accepts a resident it cannot adequately serve. Staff at one CSB stated that their efforts to encourage more selectivity on the part of ACR administrators has reduced the number of problems at ACRs, including the number of complaints and the need for emergency services.

Recommendation (4). **Better communication between community services boards, adult care residences, and the Department of Mental Health, Mental Retardation and Substance Abuse Services is needed to ensure that placement policies are followed. Community services boards should carefully monitor new adult care residence placements in which they play a role. Community services board staff should routinely visit and communicate with the staff of adult care facilities to ensure they are aware of changes in services.**

Individualized Service Plans

In order for an individual to be discharged from a State mental health facility to an adult care residence, DMHMRSAS requires a treatment plan to be completed. Under DSS licensing standards, the ACR must in turn develop an individualized service plan within 45 days of receiving a discharged patient. This service plan is a written description of the actions to be taken by the ACR to meet the assessed needs of the resident. DSS licensing standards state that the ACR should develop this plan in conjunction with the resident, the resident's family, case manager, health care providers, and others as appropriate. The service plan is also the basis for Medicaid's utilization review of payments for assisted living services.

Under standards, the service plan is to incorporate the resident's assessed needs as documented by the UAI, and include descriptions of identified needs, the services to be provided and who will provide them, when and where the services will be provided, and the expected outcome. To ensure that the resident is receiving appropriate care, standards require the service plans to be reviewed and updated every 12 months.

During site visits, JLARC staff found that service plans were rarely individualized, and they did not always correspond to the needs identified in the Uniform Assessment Instruments. The following case example indicates the level of effort some ACRs put into the development of service planning.

> *Upon reviewing the individualized service plans in resident files during a renewal inspection of a facility containing a predominantly mental health population, the DSS licensing specialist noted to the ACR administrator that the service plans were not complete. The ACR administrator replied that she had in fact completed the service plans for the residents of the facility. The specialist noted that the service plans only contained the following statement: "continue treatment/ medication as prescribed." In turn, the administrator asked: "What do they need besides their medications?"*

According to a regional licensing administrator, "If it is a service that you provide for everyone, then it is not individualized." DSS licensing staff indicated that service plans should be specific, and not simply an exercise in paperwork. However, the majority of the service plans reviewed by JLARC staff contained the same basic information – a simple listing of ADLs and IADLs. Occasionally service plans mentioned other medical conditions of residents. For example, some plans stated that the resident needed a diabetic diet and care, or that the resident needed asthma care. One licensing staff person suggested this example:

> Suppose a resident is on Haldol. The administrator should consider why the resident is taking Haldol. What are staff going to look for with respect to the individual's symptoms? What are the side effects?

To address concerns about service plans, DSS licensing staff stated that they would be offering training in how to write the service plans. CSB staff should participate in such training to ensure that service plans adequately address the mental health needs of residents.

Recommendation (5). **In order to coordinate care between adult care residences and community services boards, the General Assembly may wish to amend the *Code of Virginia* to require a resident's community services board case manager (where one is assigned) to participate with the adult care residence in the development and updating of individualized service plans. Community services board staff should also participate with the Department of Social Services licensing staff to provide training on the development and implementation of service plans.**

Medication Administration

Medication administration in ACRs has continually been cited as problematic. New techniques of packaging medications, such as blister packs, Compudose, and Medicine on Time have improved the administration of medications in ACRs and helped reduce errors. However, protocols for the proper administration of medications often remain ignored.

Proper management of medications is a critical concern for ACR residents in part because, according to UAI data, residents who are also auxiliary grant recipients take an average of seven prescription medications. Most medications require multiple daily doses. In addition, the stability of many persons with mental illness depends upon proper medication management.

Serious side effects are an additional reason for careful attention to medications. Many residents with mental disabilities take multiple psycho-pharmacological medications, including Clozaril, Lithium, Haldol, and Benztropine. Use of these drugs requires extremely close monitoring, including weekly bloodwork, because their use can lead to other serious medical conditions. Exhibit 4 lists medications frequently prescribed for residents with mental disabilities in ACRs, and indicates some of their side effects which lead to need for monitoring.

During the course of this review, numerous problems were observed with the administration of medications in ACRs. Problems included lack of basic knowledge about medication management, improper administration of medications, failure to follow the protocol attendant with certain medications, and lack of adequate documentation.

> *One DSS licensing specialist recalled an incident in which she had to explain to an ACR administrator that "you can't give someone else's prescription to another resident, even if it is the same medication."*

* * *

Exhibit 4

Medications Requiring Monitoring that Are Frequently Used by Mentally Disabled Residents of ACRs

Clozaril

Clozaril is indicated for the management of severely ill schizophrenic patients who fail to respond adequately to standard antipsychotic drug treatment. Because of the significant risk of agranulocytosis and seizure associated with its use, Clozaril should be used only in patients who have failed to respond adequately to treatment with appropriate courses of standard antipsychotic drugs. Patients who are being treated with Clozaril must have a white blood cell count every week throughout treatment. The distribution of Clozaril is contingent upon performance of the required blood tests.

Haldol

Haldol is indicated for use in the management of manifestations of psychotic disorders. A syndrome consisting of potentially irreversible, involuntary, dyskinetic movements may develop in patients treated with antipsychotic drugs. It is impossible to predict, at the inception of antipsychotic treatment, which patients are likely to develop the syndrome. The syndrome can develop after relatively brief treatment periods at low doses.

Benztropine

For use as an adjunct in the therapy of all forms of parkinsonism. The drug may cause complaints of weakness and inability to move particular muscle groups. Mental confusion and excitement may occur with large doses, or in susceptible patients. Patients with mental disorders should be kept under careful observation, especially at the beginning of treatment or if dosage is increased.

Lithium

Lithium carbonate is indicated in the treatment of manic episodes of manic-depressive illness. Outpatients and their families should be warned that the patient must discontinue lithium carbonate therapy and contact the physician if such clinical signs of lithium toxicity as tremor, mild ataxia, drowsiness or muscular weakness occur. (The drug) may impair mental or physical abilities.

Source: *Physicians' Desk Reference.*

One medicine requires that a resident's pulse be taken when the drug is administered. At one ACR, the individual administering medications failed to take a pulse. After prompting by a licensing specialist, she took the resident's pulse. However, she did not know what the appropriate pulse level should be for that individual. The worker simply noted the resident's pulse in the records, without being able to make a judgment as to whether that pulse rate was within a normal range.

* * *

A psychiatric nurse conducted in-service training for medication administration and monitoring using the medication administration records of residents at the ACR. While there, she found that one resident was taking 13 different medications. The prescriptions were written by several physicians and psychiatrists. After consultation with the physicians, psychiatrists, and pharmacist, the resident was reduced to taking only four medications, thus reducing costs to the resident, the potential for errors, and potential drug interactions.

* * *

The charting of medication was not taking place as medications were distributed at one ACR. The nurse in charge of the distribution of medications stated that the medications were charted in the office after they were distributed to the residents. When asked about how she could remember what each of the 60 residents, many of whom took multiple medications, had received, the nurse responded that "you get to know your residents."

* * *

One staff member distributing medications in an ACR wandered around the dining area during lunch time with pill cups in her hands looking for the residents. The staff member did not have a medication chart or any other way to document what had actually been received. During reviews of resident records, JLARC staff found that medication administration record (MAR) cards were signed, but there was no indication that the medications had been distributed.

* * *

JLARC staff visited a seven bed ACR in which the administrator was the only staff member trained in medication administration. The administrator had another full-time job and was one of only two staff people at the facility. The administrator was not at the ACR at night, despite at least one resident requiring the administration of medica-

tion at that time. Standards require that medications only be administered by someone certified to do so or by someone who has taken a medication administration class from DSS.

The use of medications is crucial in allowing the chronically mentally ill population to live in the community in settings such as ACRs. However, the potent side effects of some of these medications if not properly administered or the consequences of some residents not receiving medications as prescribed, can pose a danger to ACR residents. Based on the review of homes visited by JLARC staff, more consistent and careful monitoring is needed in some ACRs.

In addition, the licensing standard related to medication administration needs to be revised. DSS licensing standards require that all staff responsible for medication administration to have successfully completed a medication training program approved by the Board of Nursing or be licensed by the Commonwealth to administer medication. However, JLARC staff found some ACRs in which only one staff person was certified to administer medications. As the case example above illustrates, it is impossible for one person to be available at all times. In order to meet the current standard, some ACRs have a contractual agreement with a certified service provider for the administration of medications. Yet, JLARC staff found that this was not always the case. As a result, medications may be dispensed by individuals without proper certification, potentially endangering residents. Improper administration of medications or inadequate monitoring of medications should be a priority concern for DSS. DSS may want to consider the use of financial penalties to enforce requirements related to medication administration.

Recommendation (6). **The Department of Social Services licensing requirements should provide for more than one staff person at an adult care residence to be trained in medication administration or require the ACR to enter into a contractual arrangement with a certified service provider to ensure that all medication is dispensed by individuals certified in medication administration. The Department should also consider improper administration of medications and inadequate monitoring of medications to be a serious violation of health and safety standards, and may want to impose financial penalties for such violations.**

Behavior Monitoring and Supervision

Supervision and assistance are key features distinguishing ACRs from independent living. Supervision and monitoring of residents is crucial to detecting behavioral changes that may stem from the potent medications prescribed for many persons with mental disabilities. Failure to adequately monitor residents can lead to serious consequences if, for example, side effects of medication are not noted, or if residents remain unaccounted for over several days. DSS standards require general supervision for safety and medication administration. Under the standards, assistance with the

activities of daily living also requires staff involvement with residents. Direct care staff are also required to be trained in the care required by residents. There is, however, no explicit staffing standard to ensure effective supervision.

Currently, there is no statutory basis for a staffing standard. The 1991 General Assembly directed the State Board of Social Services to adopt regulations governing ACRs, including standards for staffing. In 1995, the General Assembly amended the *Code of Virginia* to require adult care residences to "have adequate and sufficient staff to attain and maintain the physical, mental, and psychosocial well-being of each resident." However, regulations no longer had to include standards for staffing.

During site visits, JLARC staff found supervision to be lacking in 11 of 35 ACRs. The following examples illustrate JLARC staff's observations.

> *One ACR which housed 19 residents had only one staff person on duty. This individual served as the administrator, cook, direct care staff, housekeeper, and maintenance crew.*

* * *

> *In an ACR serving approximately 300 residents, JLARC staff found that no direct care staff were present in one wing of the facility, containing 70 residents. The only person present in the wing was a member of the housekeeping staff. In this same ACR, staff indicated that they did not know where certain residents were when asked by the DSS licensing specialist.*

* * *

> *At another ACR, staff were not present in a wing predominantly for 32 residents with mental illness. When the administrator was asked about staff in this wing, she explained, "There is one staff person assigned to that area." She added, "Those people are independent; they can do for themselves."*

* * *

> *In an ACR housing 45 residents, the five staff members on duty during the day included the administrator, the assistant to the administrator who also had direct care responsibilities, a nurse, one individual who served as kitchen and housekeeping staff, and one individual who performed housekeeping duties and resident care part time. Most of the residents were unsupervised throughout the facility. The administrator told JLARC staff, "We do the best we can with this population." She added, "We have not had any deaths or pregnancies."*

* * *

At another ACR licensed for more than 150, a staff office had recently been constructed away from the main entrance corridor, "so staff wouldn't be bothered by the residents," according to the administrator. At the time of the JLARC visit, most of the direct care staff were in the office with the door shut. Residents on upper floors were completely unsupervised.

Compliance with existing standards is not readily apparent when an ACR does not provide sufficient supervisory staff to know where residents are, or when non-supervisory personnel such as cooks or janitorial staff are also expected to monitor residents' behavior or assist with daily living activities of residents. Persons with certain mental illnesses, such as schizophrenia, often withdraw from other people and seek isolation, yet can effectively engage in interaction if someone makes the effort. As indicated in Table 11, behavior ranging from passivity to aggression are characteristic of many ACR residents.

Table 11

Behavior Patterns of Auxiliary Grant Residents

Behavior	Residents with MI or MR Diagnosis	All Auxiliary Grant Residents
Appropriate behavior	57%	74%
Wandering/passive (less than weekly)	4%	3%
Wandering/passive (weekly or more)	5%	4%
Abusive/aggressive/disruptive (Less than weekly)	18%	10%
Abusive/aggressive/disruptive (weekly or more)	16%	9%

Source: JLARC analysis of UAI database.

Despite these clear needs for attention, during site visits JLARC staff often observed little interaction between staff and residents. In some ACRs, staff members or the administrator did not seem to know the names of residents. Often, residents were gathered in one large room with a television turned on, without any staff presence.

While DSS standards currently require ACR staff to have a general level of knowledge about the care needs of residents, there appears to be a need for a specific requirement for direct care ACR staff to receive training in the behavioral symptoms of mental disabilities and how to effectively monitor the behavior of individuals with mental disabilities. CSBs should routinely offer such training to ACR staff. DSS should

consider lack of supervision, or supervision by inadequately qualified staff, a serious violation of standards, and may want to assess a financial penalty for such violations.

Recommendation (7). **The Department of Social Services standards for adult care residences should be revised to include a more specific requirement for direct care staff to receive training in the behavioral symptoms of mental disabilities and how to effectively monitor behavior of individuals with mental disabilities.**

Recommendation (8). **The General Assembly may wish to amend the *Code of Virginia* to require community services boards to routinely offer training in the behavioral symptoms of mental disabilities and how to effectively monitor behavior of individuals with mental disabilities to adult care residence staff.**

Recommendation (9). **The General Assembly may wish to provide the Department of Social Services with the authority to develop an appropriate staffing standard to ensure the adequate supervision and care of ACR residents. Additionally, the Department of Social Services should consider the use of financial penalties to enforce standards related to supervision of adult care residents.**

SERVICES FROM CSBs COULD BE ENHANCED

DMHMRSAS's referral of individuals from State facilities to ACRs began in the 1970's during deinstitutionalization. Though many of the residents currently in ACRs are post-hospitalized individuals, oversight of ACRs rests with DSS through its licensing activities. DMHMRSAS's primary contact with the residents in ACRs is through the community services boards (CSBs). CSBs are local providers of mental health services, funded through State, local, and federal sources.

Based on a survey of community services board case managers, an estimated 2,640 ACR residents are served by CSB case managers across the State. Some of this study's target population receive services from private providers, such as psychiatrists and staff at ACRs, while others receive services from CSBs.

Currently, every Virginia locality is served by one of the 40 CSBs. Core services provided by all CSBs include emergency services; inpatient, outpatient and day support services; residential services; and prevention and early intervention services. CSBs also enable individuals with mental illness, mental retardation, or substance abuse problems to access services in State mental health and mental retardation facilities through pre-admission screening, case management, and client services management.

The inpatient population at State mental health facilities has declined in recent years. Data from DMHMRSAS indicates that the census at State facilities dropped 19 percent between FY 1992 and FY 1996. This has been accomplished through several methods, including making special funding available to CSBs for serving former State facility clients in the community.

Interviews with CSB staff indicated that this special funding mechanism may serve to keep persons in community placements and in ACRs who, in the past, might have been admitted to a State facility. In addition, patients discharged from State facilities to the community today may have more needs than those individuals discharged in the past, according to CSB staff. As these individuals with more serious illnesses and more intensive needs are now being placed or remaining in the community, the needs of ACRs for emergency services and case management assistance from CSBs are increasing.

Emergency Services

Emergency services are the only services mandated by the *Code of Virginia* for CSBs to provide. Emergency services typically consist of crisis intervention, stabilization, and referral assistance over the telephone or face to face, for individuals seeking such services for themselves or others. These services are required by DMHMRSAS regulations to be available 24 hours per day, seven days per week. Emergency services may include home visits, jail interventions, pre-admission screenings, and other activities for the prevention of institutionalization or associated with the judicial commitment process. The provision and location of emergency services varies by CSB.

In many cases there appear to be significant differences of opinion among ACR administrators and CSB staff about what constitutes an emergency, whether services should be provided, and if so, whether services will be provided at the ACR, at the CSB, or elsewhere.

JLARC staff consistently heard from CSB staff that ACRs call emergency services for reasons concerning residents' behavior. CSB staff expressed frustration that they were being called for behavior that is symptomatic of a resident's mental illness, or other problematic situations, which were not emergencies. They stressed that emergency services are intended by the *Code of Virginia* for cases in which a resident has placed himself or others in imminent danger.

A large gap exists between the definition of emergency services used by ACR staff versus that which is codified and utilized by CSBs. The following case illustrates the consequences of this gap:

> *One administrator complained that the CSB's emergency services staff would not come to the ACR. The administrator said that once she had called emergency services when a resident held a piece of glass to her*

throat, and was told by mental health that the incident was behavioral. No services were offered.

The administrator also said that after 9:00 p.m. the emergency services workers tend to categorize most incidents as behavioral. She stated that there is a direct correlation between the time of day that a call is placed and the response of the CSB. The administrator added that if so many of these emergencies are categorized by mental health as behavioral, then mental health should offer some type of behavior modification program.

JLARC interviews with ACR staff and administrators pointed to a difference in emergency service provision during regular business hours versus evenings and weekends. The JLARC survey of ACR administrators further illustrates this point. Of the 77 ACR administrators that have tried to obtain emergency services after 5:00 p.m. or on weekends, 59 percent reported difficulty in actually acquiring the services. Of the 89 respondents who tried to obtain emergency services from 9:00 a.m. to 5:00 p.m., 43 percent reported having difficulty at least some of the time. According to the State Ombudsman for Long Term Care:

> Some CSBs are only providing emergency or crisis services. They are not providing education or training to ACR staff. If this is all the CSB can provide, then one could just as easily call the police.

JLARC staff found that several CSBs will not provide emergency services inside adult care residences. These CSBs require ACRs to transport residents to other locations, such as a hospital, magistrate's office, or jail, to be handled by those parties. ACR administrators stated that transporting a psychotic individual who is having a crisis poses a safety problem. In addition, the ACR staff noted that residents with mental illness will often behave differently when they are removed from their environment, but will once again exhibit the problem behavior upon return to the ACR.

In order to bridge the gap between these differing views of emergency services, there needs to be more frequent and effective communication between CSBs and ACRs. As the local agency with expertise in the area of managing mental disabilities, CSBs should provide training to ACR administrators and direct care staff regarding emergency services, the symptoms of mental illness, and related issues. How to manage various client behaviors should be an essential part of the training. Direct care staff at ACRs should be required to participate in the training.

Recommendation (10). **Community services boards should ensure that adequate staff are available to provide emergency services to individuals within their catchment areas. Community services boards should be required to provide emergency services in adult care residences. In addition, community services boards should provide training to adult care residence administrators and direct care staff on the legal parameters of emergency services,**

how to manage emergency situations, crisis interventions, side effects of medications, and dealing with aggressive behaviors.

Case Management Services

The goal of sound case management is to provide a variety of support services to individuals with mental disabilities and their families. CSB case managers can be an essential connector between the individual client and the services and resources of the CSB and other community service providers. Case managers perform many services for their clients, including needs assessment, service planning, assistance in locating and obtaining needed services and resources, coordinating services with other providers, monitoring service delivery, and advocating for services that are responsive to the changing needs of clients.

As CSBs came under Medicaid service provider requirements in the early 1990s, some case management services became reimbursable under the federal program. Medicaid funds case management as long as there is one quarterly face-to-face visit by a case manager with the Medicaid-eligible client.

Effectiveness of Case Management. As a link between clients who reside in ACRs and community services, case managers are sometimes almost an extension of the ACR. Staff at one CSB visited by JLARC were explicit about this role, noting that:

> CSB case management is a wonderful bonus for the homes. It is a link or bridge to all community resources for the residents.

The effectiveness of case management services often depends upon the size of the case manager's caseload. Very large caseloads constrain the case manager's ability to maintain regular contact with the resident. JLARC's survey of CSB staff with ACR clients found that case manager total caseloads, including both ACR residents and others, ranged from two clients to 138, with a statewide median of 41. High caseloads can lead to infrequent contact with clients. While clients with mental disabilities who are stable may require less frequent contact, the lack of adequate contact can lead to gaps in services and the lack of continuity.

Of the CSB case managers who responded to the JLARC survey, 31 percent indicated that they visited clients in their respective ACRs less than once per month. While quarterly visits are all that DMHMRSAS regulations require, 22 percent of the case managers indicated they were unable to spend adequate time with clients residing in ACRs. This is a concern because 53 percent of case managers reported that they provide most of the mental health services received by clients.

Another concern is that ACR staff do not always welcome involvement with their residents by the CSB. Like DSS licensing employees, the CSB staff may be among the few outsiders concerned with resident care who routinely enter the ACR. However,

according to ACR administrators and DSS licensing staff, some case managers do not actually visit their clients face-to-face or provide any services, but only interview facility staff about clients.

While service provision can hardly occur under such circumstances, a greater concern is the apparent refusal of some ACRs to allow CSB staff to enter the facility:

> *One ACR administrator told JLARC staff that there was a problem with CSB case managers and that they were not going to be allowed into her ACR. She added that the case managers were providing residents with false hopes, so the she was not going to allow the case managers into her facility.*

JLARC staff found that some CSBs will not provide case management or other services, such as psychosocial rehabilitation, to ACR residents unless the residents are also patients of the CSB's mental health clinic. While this may be intended to ensure that the residents receive needed treatment, it may also preclude some residents who are being seen by private providers from receiving case management services.

Recommendation (11). **The General Assembly may wish to amend the *Code of Virginia* to require adult care residences which accept auxiliary grant recipients to allow community services board case managers into their facilities to assist residents. Community services boards should ensure that their case managers actually spend adequate face-to-face time with their clients to determine whether their residents' needs are being addressed.**

Services for Substance Abuse Residents

Three percent of auxiliary grant recipients have substance abuse as a secondary diagnosis, based on assessments completed in 1996. However, DMHMRSAS, CSB, and ACR staff stated that many ACR residents have a history of self-medicating their illnesses with alcohol and drugs. In addition, many substance abusing residents may remain undiagnosed.

According to CSB staff, many of these residents are more mobile, active, and younger than many of the other ACR residents. Due to substance abuse problems, many of these residents have difficulty developing and maintaining social and work skills. The service needs of this population are diverse, ranging from outpatient counseling to more intensive detoxification and treatment services.

Substance Abusers in ACRs. DMHMRSAS and CSB staff noted that the conditions of many substance abusing residents often do not improve in ACRs. ACRs do not necessarily provide the level of supervision required to prevent the resident from seeking out or participating in substance abusing behaviors. In addition, many ACRs are in locations that may not be ideal placements for substance abusers. According to several case managers with substance abusing clients, clients who can come and

go from an ACR typically have access to their drug of choice. CSB staff further noted that because there are not enough residential treatment beds to accommodate the need, ACRs are often the only available option. However, 40 percent of the ACR administrators responding to the JLARC survey indicated they do not accept substance abusing residents into their facilities. Similarly, 34 percent of the ACR administrators that responded to the survey and had at least one auxiliary grant resident in their facility stated that that they did not accept substance abusing residents.

While some ACRs indicated that they specialize in serving a substance abuse population, JLARC staff found that specialization did not necessarily indicate treatment expertise. Instead, specializing often meant that the majority of the population in the ACR had a specific diagnosis. State standards do not require that staff in ACRs specializing in substance abuse or other special populations necessarily have additional training or expertise in the specific disability. Sometimes, for substance abusing residents of ACRs, attending programs sponsored by Alcoholics Anonymous or Narcotics Anonymous is the extent of treatment available.

Although some form of substance abuse services are available statewide from all CSBs, according to 20 percent of ACR administrators responding to the JLARC survey, substance abuse services are rarely or never available to their residents through the CSB.

CSBs offer residential as well as day support programs for substance abusers, although these are not available in every locality. Residential programs include detoxification and therapeutic programs. These residential services are limited with respect to length of stay.

- *Residential detoxification*, offered by 24 CSBs, provides services lasting from three to 14 days in non-hospital settings with 24-hour staff. Residential detoxification services include health care, discharge planning and case management.

- *Residential primary services*, offered by 22 CSBs, usually last no more than 30 days, and include intensive stabilization, daily group therapy and education, client monitoring, case management, individual and family therapy, and discharge planning.

- *Residential therapeutic* services are provided in 16 CSBs. The rehabilitation services include group therapy and psychoeducation, client monitoring, case management, individual and family therapy, employment services, and community preparation services. The length of stay typically exceeds 30 days.

Detoxification is often the first step in the treatment of substance abusers. However, use of State hospital beds by CSBs is limited across the State. Hospital detoxification is medical care for the detoxification of people with severe medical complications associated with withdrawal. This type of acute care is offered in only 11 CSBs. Methadone treatment and maintenance services combine outpatient treatment

with the administering and dispensing of methadone as a substitute narcotic drug in decreasing doses to reach a drug free state. As of January 1997, nine CSBs were operating methadone programs.

Day support and work programs, and outpatient services are needed to teach basic skills to provide support to the client. Day support services include structured programs of substance abuse treatment activity generally provided in clusters of two or more continuous hours per day. Day support services are similar to psychosocial rehabilitation programs for mental health clients. However, day support services for substance abusing residents are limited. Of the 40 CSBs, 21 offer a day treatment program for substance abusers.

Recommendation (12). **The Department of Social Services and the Department of Mental Health, Mental Retardation and Substance Abuse Services should consider developing staffing and programming standards for adult care residences with significant populations of residents with histories of substance abuse. These could include: (1) standards for staffing sufficient to limit residents' access to street drugs, (2) requirements permitting adult care residences to accept persons with active substance abuse problems as residents only if enrolled in a suitable treatment program, and (3) standards to require that services be provided by the community services boards or other qualified provider of substance abuse services.**

Linkages Between ACRs and CSBs

During the course of this review, JLARC staff identified two CSBs with staff who function as liaisons or coordinators between the CSB and ACRs in the area. Both CSBs had determined that their catchment areas contain a large number of CSB clients residing in ACRs, and dedicated an employee to assisting the case managers in ensuring that services are provided to the clients.

> *One large CSB, for example, assigns one staff person as ACR liaison. The job involves not only assisting case managers in writing treatment plans and in active case management with more than 100 ACR residents, but also following up to see that residents are receiving the necessary services and, when necessary, training ACR staff in the symptoms of and appropriate responses to mental disability. A senior manager with the CSB said that this liaison has enough visibility and credibility that sometimes if she just shows up at an ACR a crisis situation will be resolved.*

ACR administrators interviewed by JLARC in this CSB's catchment area agreed that this liaison person played a key role in ensuring satisfactory services and relations with the CSB.

JLARC staff found that in the other CSB with the "consultant" or "liaison" program, relations between the CSB and ACRs have improved. The consultant is able to answer questions and address concerns of administrators and direct care staff. By visiting ACRs on a regular basis, the consultant can also identify residents that may require mental health or mental retardation services and help link these individuals with needed services. In this catchment area, consultants have worked with ACRs on a variety of topics, including de-escalating crises; developing activities appropriate for the population being served; symptom monitoring; informing ACRs about service needs of potential residents before residents are permanently admitted; and linking individuals to community supports. This CSB staff person indicated that the two most significant features of the program are "the increased coordination of services and the establishment of a better working relationship between CSBs and ACRs."

Other CSBs with significant concentrations of ACRs with residents who have mental disabilities should consider assigning a staff person to this specialized caseload. In addition to assisting case managers with their ACR clients, the person should play the role of liaison between the CSB and ACR staff. This heightened visibility for the CSB can improve relations between CSBs and ACRs, provide ongoing training and assistance to ACRs in supervising residents with mental disabilities, and help ensure the smooth provision of services to CSB clients who reside in ACRs.

Recommendation (13). **The General Assembly may wish to consider providing sufficient funding for each community services board with a threshold number of clients who reside in ACRs to have a staff position focused on ensuring that services are provided to this population. Key ancillary duties would include training and technical assistance to adult care residence staff.**

IMPROVED ENFORCEMENT OF STANDARDS COULD ENHANCE SERVICES FOR RESIDENTS

The State began regulating adult care residences in 1954. Since that time, regulation has been the responsibility of the Department of Social Services or its predecessor agencies. The statutory goal of licensing and monitoring ACRs is to protect the health, safety, and well-being of their residents. This protection is particularly important since regulatory authorities may be the only outside entity concerned with resident care that enters the ACRs on a regular basis.

The changes made over the last several years to the regulatory framework governing ACRs have been substantial. An assessment of the regulation of ACRs indicates that licensing standards have been significantly enhanced, with increased education and training required for ACR employees, enhanced requirements for medication management, and other important improvements. All ACRs were inspected in 1996 for compliance with the new standards.

The 1990 JLARC review of homes for adults recommended several improvements to DSS licensing standards. Several recommendations required legislation, such as establishing more than one level of care, which was adopted by the 1993 General Assembly. The higher level of care, assisted living, was further divided into two sub-levels, each with increased payment, by legislation adopted in 1994. Thus, DSS licenses ACRs to provide either of two levels of care, while for purposes of payment there are three care levels.

Other JLARC recommendations have also been adopted. The 1993 legislation also clarified the types of care and assistance which could be provided by ACRs, and prohibited ACRs from accepting residents with certain medical conditions. Additional improvements in the standards include requirements for ACR staff to be literate, to be at least 18 years of age, to follow physician's orders concerning the care of residents, and clarification of what specific services are to be provided by the auxiliary grant payment.

These changes to standards have significantly improved the basic health and safety of residents. Now, DSS needs to refocus on certain issues related to enforcement of the standards. In addition to ACRs and CSBs enhancing services, DSS needs to focus on certain fundamental enforcement actions.

If ACRs are to be an effective long-term alternative to institutional care for persons with mental illness and mental retardation, DSS will have to ensure that fundamental enforcement actions are taken to enhance the general quality of life in ACRs. Among the most important of these actions are better defining "assisted living," enforcing licensing standards in a more timely fashion, applying the Practitioner Self-Referral Act to ACRs, and adopting a team approach to licensing.

Assisted Living Needs to Be Better Defined

The major differences between residential and assisted living relate more specifically to the needs of the resident than to the services provided to the resident. In fact, a review of the standards indicates few differences between the services required for residents who need assisted living, and the services required for persons at the residential living level of care.

The assisted living level of licensure sets higher requirements for the education and training of ACR staff, health care oversight, and the amount of activities offered. Facilities at this level of licensure are also required to ensure that the restorative and habilitative service needs of the residents are met. As defined in the standards:

> Assisted living means a level of service provided by an ACR for adults who may have physical or mental impairments and require at least moderate assistance with the activities of daily living.

> Residential living means a level of services provided by an ACR for adults who may have physical or mental impairments and require only minimal assistance with the activities of daily living.

There is no explicit requirement for additional staff or for daily help with the activities of daily living (ADLs). Differences between the levels of care need to be stated in the standards in terms of services provided to residents, and not just in terms of residents' needs. Providing "moderate" assistance instead of "minimal" assistance does not adequately distinguish the two levels of care.

The enhancements beyond residential living are sufficiently minimal that ACR staff do not always see the difference. In part, this may stem from the standards' lack of a requirement that ACR administrators demonstrate familiarity with the standards. Although there is a regulation requiring that ACR staff be knowledgeable of the level of care criteria, this may not be enough. For example, an ACR administrator had failed to note that a higher level of services was required:

> *An administrator of an ACR that serves five residents, all of whom receive the auxiliary grant and have a mental illness or mental retardation diagnosis, told JLARC staff that all of the residents in her facility were assessed at the residential level. While conducting a review of resident files, JLARC staff found that one of the residents was actually assessed as meeting the requirements for assisted living. However, the facility was not licensed to provide assisted living services. When questioned, the administrator told JLARC staff that she was not aware that the resident in question was assessed at the more intensive level. She then asked the licensing specialist if she had to do anything else for the assisted living resident.*

This example of an ACR administrator being unaware of residents' documented needs also raises the question of whether the State, through DMAS' assisted living payments, may be paying for services that are not being provided. DMAS needs to implement utilization review on assisted living payments to ACRs, and DMAS and DSS should establish clear linkages between DSS licensing and DMAS payments, as discussed in Chapter IV.

The designation of some ACRs as providing assisted living, or as providing intensive assisted living, should reflect a significant difference in the amount and type of help provided to residents by ACR staff. For example, an ACR licensed to provide assisted living could be expected to have additional staff to provide the additional services. This is not currently required, despite the State's provision of additional funding to ACRs with residents with care needs at these higher levels.

Recommendation (14). **The Department of Social Services should revise adult care residence standards to more clearly define the differences in services to residents between residential living, assisted living, and intensive assisted living.**

Enforcement and Sanctions Could Be Strengthened

DSS has authority under the *Code of Virginia* and under the ACR standards to take certain actions for the violation of the standards, statutes, or for findings of abuse and neglect. These actions include administrative sanctions, civil penalties, and the appointment of receivership. Although these sanctions are available as a method of enforcement, DSS staff have indicated that sanctions are rarely employed. Instead, the department prefers to provide technical assistance and guidance to bring facilities into compliance.

DSS Takes Too Long to Bring About Compliance. Providing assistance to help facilities come into compliance is an acceptable practice within certain limits. Most licensing staff interviewed during this project seemed to exercise appropriate judgment about providing advice and not recommending specific solutions or assistance in achieving compliance. However, there need to be stricter timeframes for ACRs to achieve compliance, and DSS may need additional sanctioning authority to assist in bringing about compliance.

This concern was bolstered in the JLARC survey of CSB case managers, in which only 23 percent agreed that "DSS licensing provides adequate scrutiny of ACRs." Comments from case managers indicated they thought DSS licensing standards as well as enforcement actions should be stronger.

A key concern noted by CSB staff, advocates and residents' families, was the extended periods of time sometimes allowed for a facility to come into compliance with basic standards of care and supervision.

> *DSS worked with one large ACR with more than 350 beds to help it come into compliance from August 1995, when it was placed on a provisional license, throughout the period of this JLARC report. By May 1997, DSS was moving to revoke the license, but the ACR continued to operate and collect State funding. During this period, JLARC staff heard numerous concerns about the ACR from residents' families, friends, and advocates. Many of these concerns involved lack of supervision, such as residents being unaccounted for for several days and nights.*
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> *When JLARC staff visited this facility, staff were unable to determine whether some residents were in the facility. One resident apparently committed suicide in her room, and JLARC staff were told that it was four days before she was noted missing, even though she had missed eight scheduled and consecutive pill calls. In another instance, a resident called his mother to complain of illness and pain. When the mother called the ACR staff to check on her son, she was told he was just acting out for attention. He died the next day.*

Allowing an ACR to operate on a provisional license for more than 12 months exceeds the statutory time limitation on such licenses. Taking more than 20 months to come into compliance with basic requirements appears excessive. In a residential setting, compliance with basic health and safety standards may be so crucial that even one instance of noncompliance with key standards should warrant a penalty. It is difficult to see how having only one staff person on duty in a large ACR, or staff who are on duty but do not know whether a resident is in the ACR, meets the statutory duty to protect the health, safety, welfare, and individual rights of the residents.

One approach would be to establish penalties which would apply automatically whenever a breach of certain key standards is identified in any inspection or visit by DSS. Such standards should include lack of supervision, serious errors in the administration of medications, founded cases of abuse or neglect, and failure to provide required care.

Reasonable and specific time frames should be followed for a facility to come into compliance. In addition, DSS should establish maximum time periods for licensing staff to resolve compliance issues. Serious breaches of basic standards should not be permitted to exist for months while a lengthy review process takes place.

Timely Inspections Are Essential. Another concern is whether DSS licensing staff actually conduct the inspections for full compliance on a timely basis. In one ACR visited by JLARC staff during this study, the ACR was operating on an expired license because DSS staff had not yet conducted an inspection. Although DSS informally extends the duration of the license to cover these periods, the result is that in some cases the facility is permitted to continue in operation beyond DSS standards, and possibly beyond the statutory limit of three years.

Stronger Sanctions Are Needed. DSS needs a more effective means of enforcing ACR standards. Financial consequences should be available to DSS as a tool to bring about compliance when necessary. Another approach would be to specify which standards relate to basic health and safety, and penalize any verified breach of these standards. A CSB employee noted:

> ACR administrators know that there are no consequences to providing poor care. Nothing will happen to them anyway. The worst is a provisional license, and they will still be able to operate and receive full reimbursement for marginal care.

A more effective approach to enforcement is needed. Under current authority, DSS may reduce an ACR's licensed capacity and take other steps for violations. Identifying key standards for which any verified breach would result in a financial penalty could also provide DSS a useful enforcement tool. Tying DMAS payments to licensure status, as addressed in Chapter IV, would also be helpful in enforcing standards. To be fully effective, however, this will require significant coordination between DMAS and DSS.

Other State agencies have independent quasi-judicial authority to levy penalties and fines. For example, the Department of Environmental Quality has the authority under the *Code of Virginia* to issue an administrative order with a stated duration of not more than twelve months which may include a civil penalty of not more than $10,000. Currently, the Department of Social Services may petition a court to impose a civil penalty against any adult care residence. However, petitioning a court can result in lengthy delays in action against violators. Through the use of a quasi-judicial process, operators would be subject to expedient consequences for serious violations of the health, safety, welfare, and rights of residents.

Recommendation (15). **A stronger enforcement process should be established by the Department of Social Services, with clear timelines for enforcement action to be taken. The General Assembly may wish to consider authorizing the Department to levy financial penalties as an additional means for obtaining compliance with the licensing standards. Consideration should also be given to establishing a list of basic standards pertaining to resident health, safety, welfare, and rights, for which any verified breach of these standards would result in a financial penalty.**

Application of Practitioner Self-Referral Act

During the course of this review, DSS licensing staff and CSB staff identified concerns about several ACRs in which psychiatrists had an ownership or other financial interest, and for which they also provided treatment and health care oversight for residents with mental illness. While potentially of benefit to patients with mental illness who may have easier access to treatment, this practice can also lead to allegations of problems such as providing unneeded medical examinations and tests, and over-medication of residents to keep them docile and easy to manage in a residential setting. Use of medications "in a manner that results in a decline in the resident's functional status" or for convenience is prohibited under the DSS licensing standards.

There currently are certain restrictions on the involvement with ACRs of persons who have a financial interest in ACRs. For example, DSS standards state that the UAI must be completed:

> . . . by a person having no financial interest in the adult care residence, directly or indirectly as an owner, officer, employee, or as an independent contractor with the residence.

This places a restriction on the person conducting the assessment of an ACR resident's needs. The "Practitioner Self-Referral Act" (*Code of Virginia,* Sec. 54.1-2410 et seq.) prohibits a health care practitioner from referring a patient for health services to any entity outside the practitioner's office or group practice if the practitioner or any of the practitioner's immediate family members is an investor in such entity. However, practitioners who make such referrals and are subsequently involved with the provision of

care to the referred patient are exempted. In the case of ACRs, where many residents (especially those who are mentally disabled) have little or no family or other outside persons to check on them, this can lead to concerns about care and patient choice.

> *One CSB director stated that in her catchment area there is a growing trend toward physicians and private psychiatric groups purchasing ACRs. The CSB director stated, "This trend is disturbing," and added that these ACRs are "using inpatient care liberally and have automatic access to Medicaid."*
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> *DSS licensing staff also noted the increasing number of ACRs owned by psychiatrists and physicians. DSS staff expressed concern about the appropriateness of placements, staff ratios at these ACRs, appropriateness of care, and the profit motive.*
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> *Case managers from a CSB stated, "Client choice is an important issue," adding that ACR administrators often will not give their residents a choice about care providers. According to the case managers, "This is particularly true in the ACRs owned and operated by physicians and psychiatrists."*

The case study noted earlier in this chapter, in which an administrator of a psychiatrist-owned ACR refused to allow CSB staff into the facility, also points to a concern about health care practitioners' potential conflict of interest in referring patients to an ACR for which they are the sole medical provider. If these health service practitioners were brought under the Practitioner Self-Referral Act, they would be required to disclose their financial interest in any ACR to which they referred patients, and they would be required to provide information to the patient about alternative placements. Along with the previous recommendation that CSB employees should be allowed into an ACR which accepts auxiliary grant recipients, these steps would help reduce concerns about improper referrals.

Recommendation (16). **The General Assembly may wish to amend the Practitioner Self-Referral Act to make its provisions applicable to physicians and psychiatrists who refer patients for care in any adult care residence in which they have a financial interest.**

A Team Approach to Licensing

As the *Code of Virginia* and licensing standards have changed, the knowledge, skills, and abilities required of ACR staff and of DSS licensing personnel have also increased. While competent to assess compliance with standards, licensing staff

are not trained health care or mental health professionals and are not necessarily expert in these areas.

The quality of services is a critical concern for adult residential care providers. It is of greatest concern to the State, especially when the State is paying for the care. Involvement of experts from areas such as mental health, mental retardation, and aging can bring additional expertise to the ACR standards and to inspections.

A team approach to licensing could incorporate the assessments of experts in the relevant disciplines and bring greater expertise to bear on compliance and licensing questions. An example of how this could work is available in the children's' residential (CORE) standards. Under these standards, a residential children's facility must meet certain basic standards common to all children's residential facilities, such as structural and food service standards. If the facility also offers a specialized program such as education or mental health, then it also must meet standards in the respective "module" of standards. That aspect of the facility's program is then inspected by licensing staff from the State agency with expertise in the module.

This approach would bring additional expertise and an additional source of technical assistance to bear on ACRs. It would require that modules of standards be developed, for example by DMHMRSAS and the Department for the Aging, and each of those agencies may require additional statutory authority as well as additional staff resources. However, this approach could benefit residents by not only bringing an additional outside perspective to the issue of licensure, but also by providing an additional source of expert technical assistance to both the ACR administrator and the DSS licensing function.

Recommendation (17). **The General Assembly may wish to expand adult care residence standards by identifying State agencies in addition to the Department of Social Services which should develop modules of specific adult care residence standards, such as for the care of mentally ill, mentally retarded, and substance abuse residents. All adult care residences should be required to meet a set of core standards, and facilities that wish to serve these specific populations would be required to meet standards developed specifically for those groups. Agencies which develop special modules should also be charged with determining compliance with those standards.**

III. Best Methods of Providing Services to Mentally Disabled Residents in ACRs

House Joint Resolution 86 and Senate Joint Resolution 96 (Appendix A) direct JLARC to include in this study an assessment of the best methods of providing mental health, mental retardation, and substance abuse services to persons residing in adult care residences. During the course of this review, JLARC staff identified several models of effective and efficient service provision both within ACRs and outside of the ACR structure.

MODEL SERVICES AND PROGRAMS HELP MEET RESIDENTS' NEEDS

Best or model services generally provide flexible individualized supports to assist an individual in reaching personal goals by:

- developing individualized client support plans;
- providing services that are person-centered, not aimed at just placing people in available program slots;
- planning services jointly with the individual and the family; and
- routinely monitoring the quality and effectiveness of the supports.

Not all services provided to mentally ill, mentally retarded and substance abusing residents in ACRs have to be provided on premises. In fact, during site visits, JLARC staff found that in ACRs where residents receive intensive and individualized services, often most of the residents attend some form of day activity outside of the facility. Through the use of day programs and other outside daytime activities, the ACR can often more easily meet the needs of its residents and better direct staff hours toward times when residents are present in the facility. By using services in the community, ACRs can help ensure that the varied needs of their residents are being met.

In addition to ACRs identified as providing model services, alternative service provision models include: (1) the Home and Community-Based Waiver, which include some CSB-operated ACRs; (2) CSB-provided consultants or liaisons; (3) psychosocial rehabilitation; (4) various types of employment opportunities; and (5) programs of assertive community treatment (PACTs, also called ACTs).

Model Services Provided by ACRs

A number of factors account for better service provision for the mentally ill or mentally retarded residents residing in ACRs. These factors include: (1) staff qualifications and experience, (2) the presence of an activities director providing meaningful activities, (3) ties to the community, (4) links with the CSB, (5) resident participation in day programs, and (6) access to additional financial resources. In addition, most ACRs providing model programs were selective with respect to the type of resident that they were willing to accept. For example, most model programs would not accept substance-abusing residents, residents with a history of aggressive behavior, or residents who were unwilling to participate in training.

Ties to the Community. During site visits, JLARC staff found that ACRs that had established ties to their surrounding communities often were able to provide additional services to residents. Establishing ties to the community also diminishes some of the isolation experienced by many residents in ACRs. By developing a working relationship with the community, the ACR may be better positioned to actually provide a community-based setting for residents. When relations with the community are poor or have not been firmly established, conditions for residents often remain very similar to an institutional setting.

Some ACRs interact with the community on a number of levels. For example, one ACR arranged for discount movie tickets for its residents from a local movie theater. Another ACR established an agreement with the local YMCA so that residents could use the facilities free of charge during off-peak hours. A church near a fairly remote ACR often sponsored a number of activities, including outings and day trips. The administrator of the ACR notified residents of activities being offered and assisted those residents interested in participating. One ACR administrator noted the positive benefits residents experienced from the establishment of an adopt-a-grandparent program with a local school. Other goods or services obtained through positive relations with the community include donations of clothing and toiletries, discounts at restaurants, and reduced rates at local amusements.

Activities for ACR Residents. By regulation, ACRs are required to provide activities to residents. However, JLARC staff often found that watching television was the only observable activity. In ACRs where activities directors were present, JLARC staff observed more meaningful activities generally taking place. For example, one ACR employed a retired teacher who taught residents math, reading, and writing skills. Another ACR focused on art therapy for its residents. JLARC staff observed residents making items used to decorate their rooms, give as gifts, and sell at local craft fairs. In one ACR, the activities director coordinated activities based upon the interests expressed by the resident council. According to the administrator, participation and interest increased, because residents felt they had input into the activities.

Most residents need some structure to their days. By offering a variety of meaningful activities, ACRs are able to better provide structure for their residents.

CSB staff have stated that residents who are offered activities are less likely to withdraw or act out due their boredom. Keeping residents engaged improves their overall well-being.

Nonprofit ACR Designed to Serve Residents with Mental Illness. One specific example of an ACR offering an overall model program is an ACR operated by a non-profit organization in Chesterfield. This ACR provides private rooms and 24-hour supervision for 15 individuals. At the time of the JLARC staff visit, the ACR had a waiting list of about 70 people. By providing practical knowledge, social skills, and a structured environment, this ACR tries to stabilize individuals with chronic mental illness who have been readmitted to hospitals multiple times. After about a year at this facility, many residents are eventually able to live successfully on their own. This ACR collaborates closely with the CSB, with most of its residents receiving multiple CSB services, including targeted case management, medication management, and psychosocial rehabilitation.

During weekdays, most of the residents participate in day programs outside of the ACR. Staff at this ACR stated that the keys to the success of this facility are the high staff to resident ratio and the close relationship established with the CSB. According to the assistant administrator, there is generally one staff person on duty for every four residents. She added that staffing in this manner affords residents with the individual attention that they need.

The administrator pointed to the following experience as indicative of the ACR's success:

> *The ACR plans a week-long beach trip for the residents every year. Saving for the trip is used as a mechanism for goal setting and money management. As part of skill development exercises, residents learn to save throughout the year in order to pay for the house at the beach. For some residents, the beach trip is their first vacation.*

CSB Contracts with ACR for Skill Building. Staff at one CSB wanted to develop a program for individuals with mental illness in which the focus would be on individual attention and skill building. To deliver this type of program, the CSB contracted with a 16 bed ACR. The owner and administrator of the ACR stated that her ACR was well suited to deliver this type of program because:

> ...in a small home one can more easily get to know the residents. One can also readily see changes in resident behavior.

This ACR accepts residents interested in gaining independence and learning life and social skills. According to the CSB and the ACR administrator, individuals who are not interested in doing things for themselves will not be placed at this ACR. The ultimate goal at this ACR is to prepare individuals for less restrictive settings such as supervised or semi-supervised housing.

The program in this ACR is designed to provide structure from Monday through Friday. Residents are encouraged to take care of and pride in their home. In order to foster a sense of "ownership," residents take part in weekly household chores and meal preparation. In addition to fostering the sense that the ACR is their home, completing household tasks prepares individuals for more independent living. Along with the daily household activities, residents are encouraged to take part in current events, group discussions, interactive games, and other social activities. Furthermore, residents are also encouraged to participate in a number of programs operated by the CSB.

Home and Community-Based Waiver

In 1981, Congress adopted the Home and Community-Based Waiver. The purpose of the waiver is to contain costs and provide for less structured services needed by persons with mental retardation who want to remain closer to, and more connected with, their own communities. This section waives existing Medicaid statutory (facility oriented) requirements to help states finance non-institutional, long-term, less restrictive services in the community.

DMHMRSAS and CSB staff have lauded the waiver for its potential for promoting new and more flexible service provision methods. According to CSB staff, "the waiver increases the CSB's ability to provide more individualized services to consumers." DMHMRSAS staff stated that the waiver allows funding to be spent on service delivery instead of on facilities. Through the waiver, services can "wrap around the individual." For example, several staff members may serve as coaches, providing support to the client. Similarly, DMHMRSAS staff stated that use of the waiver "moves money out of facilities and into the community." Eligibility for services under the waiver is limited to individuals who are financially eligible for Medicaid services and have mental retardation or are developmentally at risk if under age six, and who need services provided at the nursing facility/intermediate care facility for the mentally retarded (ICF/MR) level of care.

Waiver Funding Has a Number of Advantages. The waiver increases funding for the expansion of community services. The regulatory requirements associated with the waiver improve the quality of documented supports. Waiver funding promotes a larger, more diverse system of public and private providers, which serves to broaden consumer and family choice. In addition, the waiver promotes person-centered planning and facilitates client-selected services and providers. Waiver services also have the advantage of being useable in different living arrangements, including CSB-operated ACRs.

> *In one CSB-operated ACR, all of the 12 residents received the waiver services. Through this waiver, all the residents were involved in some form of day support program. In addition, during evenings and weekends, the ACR utilized waiver funding to provide additional training in life skills and supportive living services to the residents. The ACR stressed the need for close contact between staff and residents. For*

example, the ACR had four staff persons working with 12 residents. ACR staff noted that although the paperwork requirements for the waiver were intensive, having the resources to provide additional services made the reporting requirements worthwhile.

Cost Effectiveness of Waiver. The waiver has helped increase community services and provides a cost-effective alternative to institutional care for those who need it. Nationwide, the waiver helps states avoid additional capital and operating costs for facilities. The average cost of placement in an intermediate care facility for persons with mental retardation (ICF/MR) was $82,000 per person per year nationally in 1994; the average federal-state waiver cost per participant was $33,444 for that same year. The average cost per person on the MR waiver in Virginia in FY 1996 was $37,584. However, the waiver does not pay for room and board, medical, or related costs that are included in the ICF/MR figure and in Virginia are often paid through the auxiliary grant program. In an ACR licensed to provide assisted living services, auxiliary grant funding could provide an additional $9,420 per resident per year.

Waiver services may include training, assistance, and specialized supervision that allow an individual to achieve or maintain optimum functioning. Services may also include support which allows a client to continue living with family or in another community residence. Specific waiver services include: residential support services; day support services; supported employment; therapeutic consultation; personal assistance services; respite care; nursing services; environmental modifications; and assertive technology.

A 49 percent state general fund match is required for the federal Medicaid funding of all waiver services. Match funding must be identified and accessed through an arrangement with a CSB. With only 49 percent of the costs of waiver services funded by State dollars, services over the last few years have been expanded without new appropriations. This has been possible through the conversion of existing programs, such as changing funding from 100 percent State general funds to 49 percent State funds and 51 percent federal funds. Waiver services have become a cost effective method of providing additional individualized services and support to individuals with mental retardation.

ACRs Operated by CSBs

ACRs developed out of a board and care tradition. ACRs have generally not been expected, as one CSB staff person stated, "to become treatment providers." The same staff person added, "The needs of individuals in the homes vary widely," and that she "could not understand how homes can provide care for such a wide range of residents." Similarly, one deputy director of a CSB noted, "It should be the responsibility of the mental health system to impact the residents in the ACRs." JLARC found that at least 17 ACRs are operated directly by CSBs, in part to address this responsibility.

ACRs operated by CSBs tended to offer model services to residents. These ACRs were most often characterized by: (1) greater State and local funding; (2) staff who are trained in the needs of individuals with mental illness or mental retardation; (3) a low resident to staff ratio; (4) close links to services in the community; (5) a majority of residents who participate in some form of day activity; and (6) smaller more "home-like" facilities.

Funding Availability. As discussed later in this chapter, many of the model programs or more intensive services provided in ACRs result from access to greater financial resources. Many CSB-operated ACRs rely on the auxiliary grants program as a base line of funding. To supplement the auxiliary grant, CSBs rely on federal funding, usually Waiver funding, as well as funding from localities and grants. In addition, some CSBs have chosen to use some of their State and local funding to operate ACRs.

Staff Qualifications. Most CSB-operated ACRs visited by JLARC staff were staffed by individuals trained in the needs of persons with mental disabilities. Most of the staff in these CSB-operated ACRs had Bachelor's and Master's degrees as well as experience working with individuals with mental illness or mental retardation. Due to this level of expertise, in addition to basic direct care experience, many of the staff at CSB-operated ACRs also served as counselors and trainers.

Low Client to Staff Ratios Through Participation in Day Programs. To address the shortage of housing for individuals with mental illness, one CSB decided to operate four ACRs of its own: two serving clients with mental illness and two serving clients with mental retardation. During site visits to these ACRs, JLARC staff observed that all of the residents were involved in some kind of daytime activity ranging from attending clubhouse to regular employment. Residents were responsible for cooking, cleaning, and general upkeep of the home. Staff from this CSB noted that "the key to a successful program is empowering the residents to do things for themselves." Through rich staffing levels, close contact between staff and residents may be accomplished.

Staff at the ACRs in this catchment area also serve as residential counselors. The residential counselors serve as advocates and case managers for residents, and teach residents how to advocate for themselves. For example, rather than doing daily chores for residents, staff work with residents to teach them how to accomplish these tasks on their own. In addition, staff are able to closely monitor resident behavior. This practice serves to minimize the occurrence of crises within the facility. Through close contact with residents, staff are often able to spot and defuse potential crises.

Similarly, a CSB in a different catchment area operated an ACR designed to meet the housing, case management, and daily living needs of individuals who are seriously mentally ill. In addition to their mental illness, residents of this ACR are also hearing-impaired, deaf, or deaf-blind. This ACR hired sufficient staff to ensure a low ratio between the number of residents and the number of staff. For example, while residents were present in the facility this CSB-operated ACR with nine residents had four staff on duty. During the day, only the administrator was on duty, because all of

the residents were out at various day programs or jobs. Since residents are out of the ACR during the day, participating in various programs, the ACR can make effective use of staff time by providing staff at times when residents would be in the ACR. This approach affords ACR staff more opportunities for providing needed one-on-one attention.

Staff at CSB-operated ACRs pointed to a number of success stories in which individuals who were never expected to leave State facilities were able to do so because of the services provided at the CSB-operated ACR. CSB staff relayed the following example to JLARC staff.

> *While placing a patient at a CSB-operated ACR, staff from a State hospital indicated that the individual would probably not be able to be maintained in the community. The State hospital staff said that they would refer the individual to this ACR for a trial period. A primary thrust of the program in this ACR is goal setting. As part of this program, residents are encouraged to develop plans that will assist them in attaining the goals that they have set for themselves. After less than a year at the ACR, the resident now has a job. Staff at the ACR attribute the success to the individual attention provided to residents by residential counselors.*

Smaller Facilities. During site visits, JLARC staff found that most CSB-operated facilities were small and "home-like." Residents at one ACR told JLARC staff that the ACR was their home, and added that most of them did not have family members upon which to rely, so they had to rely upon each other. Staff at another ACR told JLARC staff that "the eight people living in this facility have become the closest thing to a family that many of these residents have ever known."

Smaller settings have been cited by mental health and mental retardation advocates and CSB staff as preferable to large quasi-institutional congregate living. Of course, the size of the facilities limits the number of residents that can be served. In addition, CSB-operated facilities generally will not permit individuals with certain behaviors such as histories of consistent violence or arson into their facilities. Consequently, only a limited number of individuals may be served in this setting.

CSB Specialists Working with ACRs

As noted in Chapter II, communication between ACRs and CSBs needs improvement. To address this concern, two CSBs have developed consultant or liaison programs. The consultant or liaison provides expertise in the needs of those residents who are mentally ill, mentally retarded, or substance abusing and support to ACRs.

One CSB has designated one staff person to provide technical assistance and support to ACRs within the CSBs' catchment area. The other CSB assigns a case manager to an ACR in which some of the staff person's caseload resides.

Through the consultative process, links can be established between the housing and basic care provider and the specialized service provider. Consultants or liaisons may also help ACRs avoid potential problems through assistance with screening prospective residents. In addition, consultants can provide guidance to administrators on topics related specifically to the needs of their residents.

During site visits, JLARC staff found that some ACRs did not know what services were available to their residents through the CSB and other community services. ACRs that had a liaison or consultant from the CSB were often better linked to the services offered by the CSB or the community. These consultants are knowledgeable about services available in the area, and can inform ACRs about their availability. Consultants may also be able to identify community programs and activities for residents with specialized needs.

JLARC staff also found that consultants provided training in behavior monitoring, de-escalating crises, the warning signs of drug interactions, and communicating with individuals who are mentally ill. According to staff at one CSB, the consultative process:

> ...really helps at the front door. Now, potential problems can be dealt with early. The CSB does not have to try to serve a resident for the first time during a crisis situation.

One ACR administrator noted, "Having a consultant provides an excellent opportunity to ask questions and express concerns." One of the key benefits of the consultant or liaison program is the establishment of a connection between the ACR and the CSB for better coordination of care.

Psychosocial Rehabilitation and Employment

CSBs provide services to ACR residents who are mentally ill and mentally retarded through psychosocial rehabilitation programs and transitional employment. Called clubhouses, the rehabilitation programs provide individuals who are mentally ill with opportunities for socialization, activities, and certain treatment services. Clubhouses are licensed by DMHMRSAS, and are funded by Medicaid. Several types of employment programs prepare individuals to enter into the labor market.

According to family members of individuals with mental illness, the greatest need is "something to do all day long. Individuals with mental illness need structure for their days." Clubhouses provide structured activities, and are typically set up in clerical, kitchen, maintenance, and outreach units, where participants choose a unit and learn the skills associated with the unit.

Statewide, CSBs have the capacity for 1,727 participants in these and related psychosocial programs. Based on site visits to seven clubhouses, JLARC staff estimate that approximately 25 percent of the individuals being served by these programs are

residents of ACRs. Clubhouses generally serve younger, mobile, nonaggressive residents. There are no comparable programs for older and less mobile, or younger and more aggressive residents. However, clubhouses augment the activities required to be provided by ACRs, thus relieving them of having to provide activities and supervision for clubhouse participants for as much as half of each weekday.

Clubhouse programs foster independence and the attainment of life skills. They provide assessment; medication education; opportunities to learn and use independent living skills, and to enhance social and interpersonal skills; family support and education; vocational and educational opportunities; and advocacy within a supportive environment which focuses on normalization. Psychosocial rehabilitation emphasizes strengthening the person's abilities to deal with everyday life rather than focusing on treating pathological conditions.

Although these programs are beneficial to many participants, their relevance is limited to certain populations. DSS staff, mental health advocates, and family members of individuals with mental illness have stated that even at the best clubhouses, the programs are not for everyone, and only a limited number of people can be served.

Some older residents have been through psychosocial rehabilitation programs. These residents may no longer wish to participate. In addition, unless active treatment is taking place, Medicaid will not reimburse for the service. Other residents may not be mobile enough to take part in the planned psychosocial activities. One result is that many of the less mobile residents are left without anything to do during the day. In addition, some psychosocial rehabilitation programs will not allow residents with certain behaviors to participate in the clubhouse programs. Some clubhouses send residents back to the ACRs if they behave inappropriately.

Supported Employment. CSBs offer several other types of activities in which ACR residents are involved. A primary focus is work, through programs such as supported employment and sheltered workshops. Many ACR residents take part in these work programs.

Supported employment provides employment services to individuals with severe disabilities for whom competitive employment has not traditionally been an option. This mechanism allows many individuals to enter the competitive labor force and experience the outcomes of work that are well-known to the general population. Persons with mental disabilities who participate in supported employment tend to have fewer psychotherapy needs and require fewer therapeutic interventions.

Supported employment has two primary components which distinguish it from other vocational options such as sheltered workshops. The first is the provision of individualized supports to identify individual skills and interests (client assessment), find a job (job development), make the necessary start-up arrangements (job placement), teach the individual how to do the job (job-site training), and provide assistance for as long as the worker is employed (on-going follow-along services). Second is the role of a job coach who functions as trainer, advocate, and facilitator in providing and

coordinating the above supports. Recent innovations allow many individuals with a variety of disabilities, including those with mental illness and mental retardation, previously considered too severely disabled to work and gain the benefits of employment.

Sheltered Workshops for the Mentally Retarded. Day health and rehabilitation services or sheltered workshops, licensed by DMHMRSAS, provide individualized activities, supports, training, supervision, and transportation based on a written plan of care to eligible persons for two or more hours per day scheduled multiple times per week. These services are intended to improve the recipient's condition or to maintain an optimal level of functioning, as well as to ameliorate the recipient's disabilities or deficits by reducing the degree of impairment or dependency. Therapeutic consultation to service providers, family, and friends of the client around implementation of the plan of care may be included as part of the services provided by the day health and rehabilitation program.

Specific components of day health and rehabilitation services include the following as needed: (1) self-care and hygiene skills; (2) eating skills; (3) toilet training skills; (4) task learning skills; (5) training in time, telephone, basic computations, and money; (6) environmental skills; (7) behavior skills; (8) medication management; and (9) travel to and from the training sites, and service and support activities.

Some day programs do not have the capacity to serve the number of ACR residents that could benefit from such programs. In addition, some administrators will not permit residents in their ACRs to attend programs outside of the ACR. JLARC staff have been told by CSB staff and ACR administrators that many of these programs have waiting lists. In some areas, where a large number of auxiliary grant recipients reside, there are not enough resources to serve everyone with mental health, mental retardation or substance abuse service needs. Nevertheless, should the State wish to target resources for residents with mental disabilities living in ACRs, programs that "wrap services around the individual" should be considered.

Programs of Assertive Community Treatment

For more than two decades, the census has declined at Virginia's mental health facilities as patients have been moved into the community. The move from institutional care to community-based treatment requires an effort to provide an array of services for persons disabled with serious mental illness. In order to sustain and support these individuals in the community, programs should be flexible and able to respond to the broad range of client needs. Programs of Assertive Community Treatment (PACTs) have been cited by many mental health professionals as a cost-effective means of ensuring quality services for adults with serious and persistent mental illness. For example, one CSB deputy director stated that "PACTs are definitely the best method of providing services to the mentally ill population."

PACT Team Model of Service Provision. Assertive community treatment is based on a team model, in which a group of specialists provide a full range of medi-

cal, psychosocial, and rehabilitative services to patients with severe and persistent mental illness and associated disabilities, with the goal of preventing hospitalization. The model strives to "bring care to the patient," in order to minimize the effect of missed appointments, and to equip the outpatient with skills learned in their own homes rather than in a hospital.

PACT teams are designed to be available 24 hours a day, seven days a week. The staff-to-client ratio is high, at one to ten or less, which enables a PACT team to provide a high intensity of service when needed. A team can, for example, have several contacts in a single day with a client who is in crisis.

A typical team has five to eight clinical staff. The team usually includes a part-time psychiatrist, a registered nurse, a masters-level social worker, a bachelors-level case manager, and other professionals as needed. All staff have regular planned contact with all clients providing continuity of care on a daily basis. Teams will generally provide mental health services and work with clients in several areas of specialized psychiatric, social, and physical health. PACT staff will also arrange for other services from other systems, such as educational opportunities, social activities, and vocational programs.

The team approach also promotes continuity in services. Without a team approach, staff turnover, vacations, or other circumstances could cause disruption in services. With the PACT model, if one team member is ill or on vacation, the client will not experience any change in their support system. Other members of the team continue to serve the client. In addition, the team approach allows the specialized services or expertise to be available to the client depending on his or her changing needs. In other words, the team is designed to be flexible.

The Director of the Michigan Department of Mental Health stated:

> ACT has been a primary contributor to our ability to help consumers attain and continue their independence in the community, with dramatically reduced use of psychiatric hospitalization. For less than the cost of three psychiatric hospital beds, Michigan can operate an ACT team that serves 50 people.

By redirecting funding that, before ACT, would have paid for psychiatric hospitalization, community mental health is able to use the same funding to serve more people in the community with a preferred array of services.

Piloting PACTs in Virginia. The 1997 General Assembly provided $1,600,000 for State hospital reduction and managed care projects to serve individuals with serious and persistent mental illness and multiple hospital admissions. As part of this effort, DMHMRSAS was directed to initiate a pilot Program of Assertive Community Treatment (PACT). According to language in the Appropriations Act, the pilot is to involve one or more State facilities and communities to provide services to adults with serious mental illnesses in the community in order to reduce hospitalizations.

Currently, Hampton/Newport News CSB and Richmond CSB are participating in a federally funded assertive community treatment pilot called ACCESS. This pilot provides outreach and case management services to homeless, adults with mental illness who may also have a substance abuse problem. The Hampton/Newport News ACCESS team consists of the team leader, a registered nurse, a part-time psychiatrist, three case managers, a licensed practical counselor, a substance abuse counselor, and a consumer member. Case management staff of the Hampton CSB stated that they would like to convert to a PACT model, but they did not have the staff or the funding to do so.

Similarly, the Richmond CSB operates a mobile team. This ten person team includes a registered nurse as supervisor, one clinician, and case managers. The team is designed to provide intensive outreach to individuals with serious and persistent mental illness. In order to deliver a comprehensive set of services, the team is staffed to perform daily visits; provide crisis services; and perform medical procedures, such as blood drawings and injections.

Persons served by the mobile team have a history of requiring a high number of hospital bed days and have been previously treatment resistant. According to staff at the Richmond CSB, the individuals in this program require intensive services. As a result, a case manager acting alone would not be able to adequately meet the needs of individuals in this program. Richmond CSB staff stated that the needs of clients served by the mobile team would "burn out an individual case manager." The mobile team serves 85 to 88 cases in total. In contrast, Richmond case managers reported case loads of an average of 38 individuals.

MODEL PROGRAMS REQUIRE ADDITIONAL FUNDING

Based on the review of model programs for this report, it appears that most of these programs require funding in excess of the amounts typically available from the auxiliary grant. For purposes of cost analyses, an ACR was considered a "model" program if it: (1) was cited by CSB or DSS licensing staff as having exemplary programs for residents with mental disabilities, (2) had an extended (two or three year) license from DSS, (3) had no complaints against it, unfounded complaints, or only a few founded complaints that were minor in nature, and (4) provided audited or otherwise reliable cost data. While there may be many ACRs which meet these criteria, JLARC staff selected several for purposes of this review.

ACRs which were noted as having exemplary programs typically had a significant proportion of residents with mental disabilities who participated in CSB clubhouse programs or had active in-house psycho-social rehabilitation programs, often overseen by an activities director employed by the ACR. Several of these ACRs also have funding sources in addition to the auxiliary grant. Some are operated by nonprofit groups, which engage in fundraising aimed at supplementing the facility's operating revenues, or are operated by CSBs and receive a combination of State, local, and

federal funds. Several are funded through the Medicaid Waiver program, discussed earlier in this chapter.

In at least one case, the CSB entered into a contract with an ACR to fund additional services, with the expectation that residents will move into independent living arrangements after a stay at the ACR.

> *One CSB contracted with an ACR "to provide adequate and appropriate staff 24 hours per day, 7 days per week to provide structured rehabilitative residential activities to enhance the functioning level and community integration of CSB clients." The facility was to provide "a fully structured day to keep residents actively involved in a variety of therapeutic interventions." The contract was awarded to a 16-bed ACR which submitted a bid of $89,000 per year. The bid amounted to an additional $463 per resident per month, on top of the $695 monthly auxiliary grant, for a total monthly rate of $1,158 per resident. The CSB is satisfied with the ACR's performance, and recently renewed the contract for five years.*

Costs in these model ACRs exceed the monthly auxiliary grant rate by a significant margin. Although not necessarily representative of all such model facilities, the median reported monthly cost for these ACRs was $1,318, which was nearly double — 95 percent above — the then-maximum auxiliary grant rate of $675. Table 12 indicates the reported monthly costs for these model ACRs in FY 1995.

Table 12

Reported Costs of Selected Model ACRs FY 1995

ACR	Number of Licensed Beds	Reported Monthly Cost
A	15	$1,441
B	16	$1052
C	89	$1,328
D	149	$ 703
E	6	$1,191
CSB-Operated ACRs:		
F	9	$1,933
G	5	$1,868
Median Cost		$1,318

Note: In 1996, all of these ACRs became licensed at the assisted living level, although at the time these data were reported, this licensing level had not yet been implemented.

Source: JLARC analysis of ACR cost reports filed with DSS.

It is important to note that costs shown in Table 12 cover only the direct costs attributable to the ACRs. As already noted, in many cases there are substantial additional costs incurred by other service providers such as CSBs in serving the residents. Although these costs are not funded through the auxiliary grant program, they provide an important supplement to the services of the ACRs.

From several perspectives, the cost of providing care exceeds the funding provided through the auxiliary grant program. The additional funding available through the assisted living and intensive assisted living supplements represent significant steps toward meeting the cost of decent care, but appears to fall short of meeting the full cost. Improved services, such as those provided in model programs, may warrant increases in DMAS' supplemental payments. If such increases are supported by DMAS and the General Assembly, they should be tied to the provision of specific services for persons with mental disabilities and other special need residents of ACRs. Direct funding could also be provided for such programs.

CONCLUSION

The needs of the residents with mental disabilities who reside in ACRs can be met in a number of ways. This chapter has noted that model services for this population often stem from a close working relationship between the ACR, the CSB, and other community services. There are other models, such as assertive community treatment and supported employment programs, which can also help meet these residents' needs. As ACRs continue to evolve from a board and care tradition toward serving a more diverse population with more complex needs, the State will need to strengthen licensing and enforcement, and consider ways to ensure that services and funding meet the client's needs.

To provide the necessary services for this diverse population, additional funding for model programs may be needed. By directly funding such services instead of increasing auxiliary grants or supplemental payments, the State may be able to better address the needs of ACR residents who are mentally disabled. While the costs of services in model programs may be higher than the costs of the typical ACR with public pay residents, such costs remain well below those of alternative residential care programs paid for by the State. The model programs discussed in this chapter should be viewed, then, as cost-effective alternatives to other forms of residential care for the residents who are mentally disabled in Virginia's adult care residences.

IV. State Funding of Adult Care Residences

A combination of federal, State, and local funding sustains many residents of ACRs, especially individuals with mental disabilities. These funds include federal Supplemental Security Income (SSI) and Medicaid, and the State auxiliary grant. Many residents receive services from the locally supported community service boards as well as from other community programs.

The 1990 JLARC study recommended redesigning the adult care residence funding system to link auxiliary grant funding to the levels of care provided in the homes. This was generally accomplished in 1996 with the establishment of two levels of funding above the basic monthly payment. Problems remain, however, with the cost reporting and rate setting process, the linkage between DSS licensing and newly implemented DMAS payments to ACRs, and other aspects of State payments for care in ACRs.

PAYMENTS FOR RESIDENTIAL LIVING

Virginia has two primary mechanisms to pay for care in an ACR. The auxiliary grant, which in combination with SSI totals a maximum of $695 per month, is intended to pay for a variety of basic board and care services for the recipient, as shown in Exhibit 4. As of February 1, 1996, eligibility for an auxiliary grant was tied to an assessment of the need for residential care. Beginning August 1, 1996, additional payments of $90 and $180 per month for assisted living and intensive assisted living, respectively, were intended to provide for additional services to auxiliary grant recipients.

The auxiliary grant program is a supplement to income for recipients of Supplemental Security Income (SSI) and certain other aged, blind, or disabled individuals residing in licensed adult care residences. Currently, DSS expends nearly $20 million annually on the auxiliary grant program. About 375, or 62 percent, of ACRs have at least one auxiliary grant resident. DSS staff have stated that about 200 facilities exclusively house public pay or auxiliary grant residents.

The auxiliary grant is intended to ensure that recipients are able to maintain a basic standard of living. Eligibility for the program is typically determined by the local department of social services from the locality where the individual resided prior to entering the ACR. If the individual was in a State hospital, other State facility, nursing facility, or private hospital prior to entering the ACR, the locality where the individual resided prior to entering the State facility is responsible for providing the grant. Exhibit 5 lists the eligibility criteria for the auxiliary grant.

Exhibit 4

Services Covered by the Auxiliary Grant

- Provision of a furnished room in a facility that meets applicable building and fire safety codes;
- General supervision for safety;
- Housekeeping services based on the needs of the resident;
- Meals and snacks, including extra portions and special diets;
- Medication administration, including insulin injections;
- Clean bed linens and towels at least once a week;
- Securing health care and transportation to medical treatment;
- Provision of soap and toilet paper;
- Provision of social and recreational activities; and
- Minimal assistance with the following:
    - -- Personal hygiene;
    - -- Care of personal possessions;
    - -- Management of personal funds;
    - -- Use of telephone;
    - -- Transportation;
    - -- Obtaining clothing and personal items;
    - -- Making and keeping appointments; and
    - -- Correspondence.

Source: DSS Regulations.

Exhibit 5

Auxiliary Grant Eligibility Criteria

To be eligible for an auxiliary grant, an individual must meet all of these criteria:

- Be over 65, blind, or disabled;
- Reside in a licensed adult care residence;
- Be a citizen of the United States (most aliens are ineligible; however, there are some exceptions, including refugees, asylees, alien veterans, and aliens admitted under the Immigration and Nationality Act);
- Have a non-exempted (countable) income less than the total of the auxiliary grant rate approved for the adult care residence plus the personal needs allowance, which typically totals $735 per month;
- Have non-exempted resources less than $2,000 for one person or $3,000 for a couple; and
- Have been assessed and determined to need care in an adult care residence.

Source: DSS Division of Benefit Programs.

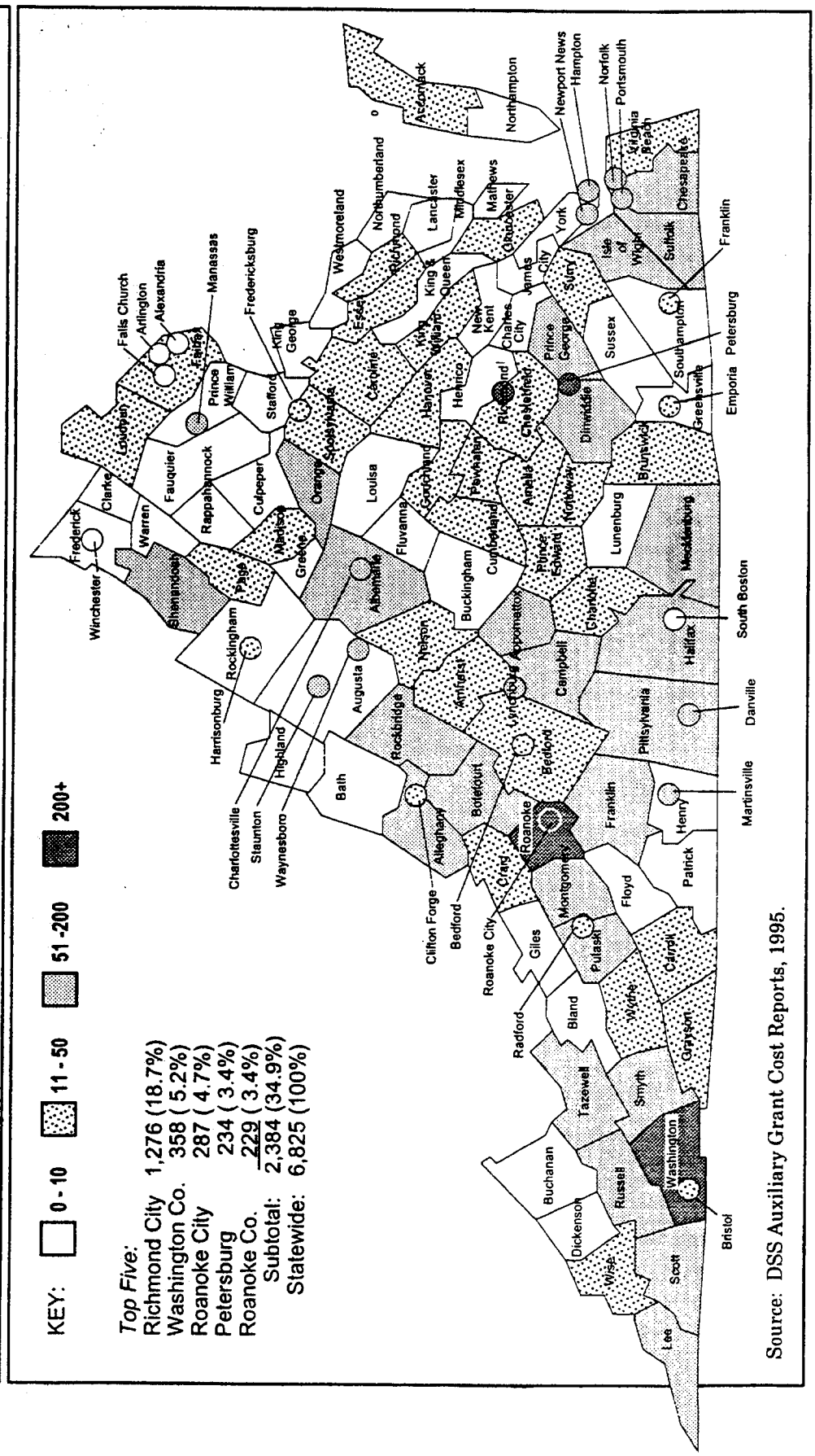
Localities Share the Cost of Auxiliary Grants

Auxiliary grant benefits are paid by the locality in which residency for the recipient has been established. Checks are mailed directly to the recipient, who in turn pays the ACR for services provided. Because there is a 20 percent local match requirement for the program, each locality that pays auxiliary grant benefits receives reimbursement from the State for 80 percent of the payment.

The 20 percent local match requirement disproportionately impacts certain areas of the State. For example, approximately 19 percent of auxiliary grant recipients statewide reside in the City of Richmond. As shown in Figure 1, the auxiliary grant population is concentrated in several areas. Five localities — Richmond, Washington County, Roanoke, Roanoke County, and Petersburg — account for 35 percent of all auxiliary grant recipients. Although these localities may not pay for the auxiliary grant for all recipients who live within their boundaries, they do expend funds for ancillary costs, such as CSB services, which may be related to these residents.

Figure 1

Estimated Auxiliary Grant Population, 1995



Source: DSS Auxiliary Grant Cost Reports, 1995.

The uneven distribution of ACRs that accept auxiliary grant recipients is important because with a limited number of such ACRs which serve these residents, localities have few options other than to relocate such individuals into ACRs in other localities with facilities able to accommodate them. This dislocation can be problematic for aged and mentally disabled persons. In addition, originating localities can reduce their own service caseloads by shifting residents to distant localities. This dislocation can make it difficult to maintain continuity of care. One advocacy group, in a July 1996 paper presented to the Northern Virginia Managed Care Task Force noted the problem this way:

> When a CSB client in Northern Virginia is shipped to a board and care home in Richmond or the Southwest, the client has lost their community but the CSB has gained a slot with no loss in funding. In this milieu, clients with the most intensive needs can become the obvious candidate for abandonment.

During the course of this study, concerns were raised by CSB and DSS staff that while some areas of the State welcome the additional clients, other areas are becoming "dumping grounds" for clients from elsewhere. The concentration of high-need, public pay clients in a few localities risks overburdening CSBs and ACRs in the receiving localities, and can lead to a concern about "warehousing" clients. This practice also impacts other local services, such as emergency medical services.

Rate Setting Process Is Unneeded

The maximum monthly auxiliary grant rate is specified in the Appropriations Act. The Act also authorizes DSS to use a rate-setting process and an 85 percent occupancy rate in setting monthly rates for individual ACRs.

The process developed by DSS requires an ACR to submit a 12-page cost report. According to regulations, rates are subsequently calculated by DSS based upon total monthly operating expenses per bed, up to the maximum rate directed in the Appropriations Act. Effective February 1, 1996, the maximum rate became $695 per month ($799 for ACRs in the northern Virginia localities of Planning District 8). Beginning July 1, 1997, the monthly maximum increases to $725 ($833 in Planning District 8). Although the Appropriations Act permits a 15 percent increment for ACRs in certain northern Virginia localities, Figure 1 indicates that relatively few auxiliary grant recipients are located there.

Cost Reports Remain Flawed. JLARC analysis of ACR cost data submitted in 1995, the most recent available, reveals flaws similar to those cited in prior JLARC reports. There continues to be no requirement that self-reported cost data submitted by ACRs be audited. While there is a requirement that the data be reconcilable to the ACR's general ledger system, a review of the data indicates discrepancies sufficient to limit the form's usefulness in determining costs at all ACRs.

Of the 425 cost reports filed for FY 1995, 16 indicated a monthly cost of more than $10,000 per bed. Four ACRs reported monthly costs under $225, including one ACR with more than 300 beds that reported a monthly cost of $47 per bed. These costs appear to result from inaccurate data submitted by the ACRs.

The DSS standards indicate that if an ACR's cost report is found to be not reconcilable to ACR records, then the monthly rate may be retroactively adjusted. DSS has not taken steps to enforce this provision, in part because of the minimal nature of the auxiliary grant rate, and in part due to the assumption that even if the errors were corrected, the facility would still qualify for the maximum monthly rate. A preferable approach may be to simply eliminate the cost reporting requirement.

DSS has recently revised the cost reporting form, effective with calendar year 1996 reports. While the new form is somewhat easier to use, and encourages the submission of tax forms to help validate the data, it retains the key flaw of allowing unaudited financial information to be submitted and used for rate setting. The new form also continues the flawed practice of adding 14 percent to an ACR's reported operating costs for "growth and inflation," thereby increasing monthly rates arbitrarily.

Rate Setting Is Not Needed. The rate setting process for individual ACRs appears to be unneeded. DSS staff indicate that all but two of the 425 ACRs which applied for an auxiliary grant rate in 1995 were approved for the full monthly amount. The rate setting process could therefore be eliminated with almost no effect on the auxiliary grant budget.

Instead of the rate setting process now in place, the auxiliary grant rate should be recommended by DSS as a part of the State budget. When it can be shown that costs of service have increased, such as a change in the minimum wage paid to many ACR employees, or will increase due to increased cost of compliance with standards, then an increase in the monthly rate may be warranted.

Some Financial Data Collection Remains Necessary. The Department of Medical Assistance Services is currently responsible for the payment of assisted living services for auxiliary grant or general relief residents of ACRs. (General relief residents are only eligible to receive the regular assisted living payments.) As steward of these funds, DMAS performs an audit function to ensure the proper utilization of State and federal funds. In addition, DMAS requires the collection of appropriate financial information for prospective rate setting. For example, without appropriate financial data DMAS would be unable to evaluate the costs of providing regular and intensive assisted living services. In contrast to the rate setting function, DMAS would not require an annual data collection effort. However, should DMAS pursue regular collection of financial information from ACRs, steps should be taken to ensure the accuracy of this reported information. Such steps may include audited financial reports for ACRs above a certain threshold level. Though DMAS should be responsible for the regular collection of financial information, this would not preclude DSS from exercising its authority to collect cost data from or perform audits of ACRs.

Recommendation (18). **The General Assembly may wish to abolish the current rate setting process and cost reporting forms used to set monthly auxiliary grant rates for individual adult care residences. Instead, the Department of Social Services should recommend an appropriate rate annually in the State budget.**

Recommendation (19). **The Department of Medical Assistance Services should collect appropriate financial data for prospective rate setting for assisted living services. The Department of Medical Assistance Services should take steps to improve the accuracy of financial information reported by ACRs.**

OTHER FUNDING FOR ACRs

The cost of care in an ACR is paid in several ways. Many residents pay privately, from their own means. Payments also come from the auxiliary grants program, as discussed above, and from supplements to the auxiliary grant program which are paid directly to the ACR by the Department of Medical Assistance Services (DMAS). In addition, each auxiliary grant recipient receives an allowance as part of the basic grant. This allowance is often the only funding available to the individual resident for the purchase of small personal-use goods and services.

Assisted Living Supplements Should Be Better Managed

A second major source of funding for ACRs took effect August 1, 1996. Under this program, Virginia Medicaid, using all general funds, reimburses ACRs a vendor payment of $3 per day for regular assisted living services, up to a maximum of $90 per month. DMAS reimburses $6 per day for intensive assisted living services, up to a maximum of $180 per month. The intensive assisted living payment is funded by a combination of State and federal dollars through a Medicaid waiver, with the federal government's share set at 50 percent.

Payments Tied to Services. The $3 and $6 per day increments were developed on the basis of a half-hour or a full hour per day, respectively, of personal care for a resident. These dollar amounts approximate a half-hour and full hour, respectively, of a minimum wage employee's time. While there is no requirement in DSS standards for any specific amount of personal care to be provided to eligible residents, DMAS plans to implement a type of utilization review process to ensure that each ACR which is reimbursed for assisted living or intensive assisted living demonstrates that personal care services are being provided to clients. During the initial implementation period (beginning August 1, 1996 and continuing into 1997), the DMAS utilization review process was suspended in order to ensure that ACRs received payments. The ACRs were told that DMAS would be initiating the review process, would be reviewing all cases submitted for payment, and would be recovering money if it was found that the client did not receive the services.

While the DMAS and DSS regulations were coordinated to ensure that the necessary safeguards were in place, there remains a problem with the DSS regulations. Despite the clear link of the assisted living payments to resident care, DSS's licensure requirements for this level of care do not explicitly require any amount of personal care. Instead, they focus primarily on staff training and resident activities (Exhibit 6). In other words, the intent of using the additional funding to provide additional personal services is met through DMAS procedures, not through DSS licensing requirements. The DSS licensing standards should include specific requirements that reflect or exceed the DMAS requirements for service provision, and should state specific service requirements, such as a minimum of one-half hour per day of personal care for assisted living residents.

Utilization Review Needed. The funding increments originated from a consideration of the costs associated with taking care of residents with more intensive service needs. However, the half-hour and hour of personal care assumptions do not correspond to actual care practices or requirements in the licensing standards. Additionally, the reimbursement did not take into account the additional costs associated with meeting the new assisted living standards. As a result, questions have arisen with regard to what services the State is actually buying with the new assisted living money.

The JLARC survey of ACR administrators indicated that the additional funding is being used primarily to offset existing costs instead of providing new or additional services to residents. Ninety-three percent of the ACR administrators who responded indicated that the additional funding would be used to offset existing costs, not to provide new services. In interviews, some administrators said they were already providing the services required for the supplemental payments.

DMAS staff are cognizant of the concern that assisted living money may be used to offset existing costs rather than to provide additional or enhanced services. As a result, DMAS is developing a utilization review process for the assisted living program. Although not currently in effect, this effort should go forward as a means of ensuring that the additional funding is used to provide the additional services needed by residents.

Payments Should Be Tied to Licensing. Another concern is that DMAS makes the assisted living payments without regard to whether an ACR has been found by DSS to have violations of licensing standards. Thus, an ACR with a provisional license due to serious problems in complying with the DSS standards will receive the full DMAS assisted living payments, as will an ACR with a three-year license and a history of full compliance.

DMAS staff have indicated a reluctance to make payments to ACRs with provisional licenses, but currently are not certain they have the authority to stop payment under this condition. They note that DSS continues to make the full auxiliary grant payment to recipients regardless of the ACR's licensure status. In part, this is due to the fact that the auxiliary grant payment is made to the individual recipient, not the

Exhibit 6

Enhancements Provided by DSS Standards and Covered by the $90 per Month Assisted Living Supplement

Staff Training:

The ACR administrator shall have two years post-secondary education, and one year of experience in caring for adults with mental or physical impairments.*

All direct care staff hired after effective date of regulations, except for licensed health care professionals, shall successfully complete training as a certified nurse aide, a nursing or geriatric assistant, a home health aide, or DSS-approved ACR-provided training. All direct care staff employed prior to regulations must either meet these requirements or demonstrate competency on a checklist of skills covered in the personal care aide training course.

Annually, all direct care staff shall attend at least 12 hours of training focused on the resident who is mentally or physically impaired.

Health Care Oversight:

The ACR is required to retain a licensed health care professional to provide health care oversight and annually review all medications used by each resident.

The ACR shall assure that all restorative care and habilitative service needs of residents are met and documented, and arranged for specialized services as needed.

Oversight is required quarterly for assisted living clients, and monthly for intensive assisted living clients.

Activities:

The ACR must provide at least 14 hours of scheduled activities per week, with no less than one hour each day.

If ACR Cares for Mentally Disabled Adults Assessed as Requiring Assisted Living:

A current (within three years) psychiatric or psychological evaluation and semi-annual progress report is required. The facility shall have a written agreement with the local CSB or other mental health clinic to make services available to all residents. The ACR shall assist the resident in obtaining services recommended in the evaluation and progress reports.

*Staff employed prior to regulations are exempted.

Source: DSS Regulations.

ACR. The DMAS payments are vendor payments to the ACR for services provided to the individual with the assessed needs. DMAS has requested an Attorney General's opinion for clarification of the agency's authority to stop payments to ACRs with provisional licenses.

When DSS has sufficient concern about the care and conditions of an ACR to issue a provisional license, there should also be consideration of a financial consequence for the ACR. In fact, the *Code of Virginia* provides DSS with limited sanctioning authority to ensure "prompt correction of violations involving noncompliance with State regulation." Consideration should be given to amending the *Code of Virginia* to authorize DMAS to reduce, withhold, or suspend assisted living and intensive assisted living payments to ACRs with provisional licenses.

Recommendation (20). **The Department of Social Services licensing standards should be adjusted to reflect the need for additional personal assistance in the assisted living category of care. Consideration should be given to identifying in the Department of Social Services standards an enhanced level of care which would correspond to the intensive assisted living level of payments provided by the Department of Medical Assistance Services.**

Recommendation (21). **The General Assembly may wish to consider amending the *Code of Virginia* to authorize the Department of Medical Assistance Services to reduce, withhold, or suspend assisted living and intensive assisted living payments to ACRs with provisional licenses.**

The Personal Needs Allowance Should Be Increased

ACR residents and administrators, mental health advocates, and staff from DSS, DMAS, and CSBs have indicated that the $40 per month personal allowance, which is authorized in the Appropriation Act, may not be adequate. Since the 1979 JLARC report, the monthly personal allowance increased from $25 to $40. If the allowance had kept pace with inflation, as measured by the Consumer Price Index during this same period, the allowance would now be approximately $54 per month. A $10 increase in the monthly allowance, bringing it to $50, would cost approximately $840,000 annually.

Any increase in the personal allowance should be accompanied by a requirement that the full additional increment be available for the personal use of the recipient. This is not currently the case. Standards permit the ACR to use $10 of the resident's personal needs allowance for the cost of doing the resident's laundry, leaving $30 per month to cover all other costs. These other costs include clothing; medical copayments; medical deductibles; personal toiletries; personal use items, including tobacco products, sodas, and snacks; over the counter and non-prescription medications; the provision of a personal phone as well as long distance telephone calls; personal transportation; and activities outside of the activities program offered by the ACR.

One activity that many residents with mental disabilities take part in is the psycho-social rehabilitation programs, or clubhouses, operated by the CSBs. These programs typically run from mid-morning through mid-afternoon, including lunch — for which the charge is typically 50 cents to one dollar. Consequently, a resident who attends the clubhouse several days each week could easily spend most of his or her net monthly personal allowance of $30 on lunch — which is already purchased by the monthly auxiliary grant. Some ACRs pack a lunch for their residents who participate in clubhouses.

Medical co-payments use up a substantial proportion of an auxiliary grant recipient's personal allowance. For example, under Medicaid, the co-payment for a visit to a doctor's office is $3, and for prescription medicines the co-payment is $1. Based on data from the Uniform Assessment Instruments administered in 1996, auxiliary grant recipients had an average of seven prescribed medications (not counting over the counter medications). Consequently, $7 of the $30 monthly net personal allowance (the amount remaining after the $10 laundry deduction) would typically be spent on medication co-payments. This would leave just $23 per month for all the resident's other incidental expenses.

The assisted living supplemental payments were developed in part to provide a less costly alternative to nursing home care for those residents that do not need 24-hour nursing care. If these ACR residents were in nursing homes, there would be no co-payment requirement.

Similar to the situation in which some ACRs pack lunches for clubhouse participants, some ACRs take other steps to address the minimal personal allowance for residents. Some ACRs provide goods and services to residents below cost or even free of charge. During the course of this study, JLARC staff learned of numerous instances in which ACRs sought out local organizations and vendors which would donate clothing and other goods to residents, or provide discounted goods and services.

Another important concern is the provision of dental and eye care services for the auxiliary grant population. Neither Medicaid nor the auxiliary grant provides coverage for these services, and the personal allowance is insufficient to provide adequate coverage. Recipients of the auxiliary grant require this type of medical service, and without a source of payment there is a significant risk that dental or eye care problems may worsen instead of being treated. To address these needs, some ACRs develop charity arrangements with local dentists and optometrists, but such free services are rarely available in all locations.

The personal allowance of $40 per month must cover a wide range items and services for residents. In addition, some ACRs charge residents for services not covered explicitly by the auxiliary grant. These additional services are often deducted from the resident's personal needs allowance. Due to their limited resources, most ACR residents can not afford to pay for expenses related to medical co-payments, dental

care, and eye care. As a result, auxiliary grant residents will often go without proper medical, eye, or dental care.

Recommendation (22). **The Department of Medical Assistance Services and the Department of Social Services should explore the feasibility of developing a medical reimbursement account for auxiliary grant residents in ACRs. DMAS should report its findings to the 1998 session of the General Assembly.**

Recommendation (23). **The Department of Social Services should conduct a review of the typical costs incurred by adult care facility residents on a monthly basis and recommend an adjustment to the personal allowance in the annual State budget process. The full amount of any increment should be provided for the personal use of the recipients.**

Appendix A
Study Mandates

Senate Joint Resolution No. 96
1996 Session

Directing the Joint Legislative and Audit Review Commission to examine and recommend the best method for providing mental health, mental retardation and substance abuse services to persons residing in adult care residences.

WHEREAS, a large number of adult care residences (ACRs), formerly known as licensed homes for adults (LHAs), have been established in the Commonwealth and are designed to serve the needs of citizens who are unable to live without the primary supports of room, board and minimum supervision; and

WHEREAS, ACRs, which are supported by Social Security, Supplemental Security Income or Auxiliary Grants, have proliferated throughout the Commonwealth and currently serve over 25,000 people; and

WHEREAS, ACRs are currently licensed by two departments of state government; a relatively small number receive licensure through the Department of Mental Health, Mental Retardation and Substance Abuse Services and are designed to render appropriate services to the mentally disabled, while a larger number of ACRs, licensed by the Department of Social Services, also house citizens with varying degrees of mental disability, but for whom there are few or inadequate services appropriate to their disability; and

WHEREAS, while legislation has established a two-tiered system of services for the ACRs under the Department of Social Services and has authorized appropriate funding which would better provide for the needs of the mentally disabled, regulations, which have been under negotiation for two years, have only recently been adopted; and

WHEREAS, the pressure for deinstitutionalization of state facilities for the mentally disabled, as a means for balancing budgets and funding other state projects, has resulted in an increasingly urgent need for community services for which there has never been adequate funding and has resulted in the placement of more deinstitutionalized adults in ACRs without adequate funding for services or oversight; and

WHEREAS, anecdotal reports suggest that living conditions in some of these homes are poor and, in some instances, warehousing in large, facility-like housing has occurred; and

WHEREAS, parents and advocates for the mentally disabled are increasingly concerned that the lack of funding, services and responsibility for the mentally disabled in ACRs

is resulting in (i) potential regression of the health and developmental condition of mentally disabled residents; (ii) potential danger to themselves or others should residents of varying social and cognitive capabilities be housed in close proximity without proper supervision, and (iii) the relative instability of some placements; now, therefore, be it

RESOLVED by the Senate of Virginia, the House of Delegates concurring, That the Joint Legislative Audit and Review Commission be directed to examine and recommend the best method for providing mental health, mental retardation and substance abuse services to persons residing in adult care residences, including specific recommendations for funding and determination of services.

All agencies of the Commonwealth shall provide assistance to the Joint Legislative and Audit Review Commission, upon request.

The Joint Legislative Audit and Review Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix A (continued)
Study Mandates

House Joint Resolution No. 86
1996 Session

Directing the Joint Legislative and Audit Review Commission to examine and recommend the best method for providing mental health, mental retardation and substance abuse services to persons residing in adult care residences.

WHEREAS, a large number of adult care residences (ACRs), formerly known as licensed homes for adults (LHAs), have been established in the Commonwealth and are designed to serve the needs of citizens who are unable to live without the primary supports of room, board and minimum supervision; and

WHEREAS, ACRs, which are supported by Social Security, Supplemental Security Income or Auxiliary Grants, have proliferated throughout the Commonwealth and currently serve over 25,000 people; and

WHEREAS, ACRs are currently licensed by two departments of state government; a relatively small number receive licensure through the Department of Mental Health, Mental Retardation and Substance Abuse Services and are designed to render appropriate services to the mentally disabled, while a larger number of ACRs, licensed by the Department of Social Services, also house citizens with varying degrees of mental disability, but for whom there are few or inadequate services appropriate to their disability; and

WHEREAS, while legislation has established a two-tiered system of services for the ACRs under the Department of Social Services and has authorized appropriate funding which would better provide for the needs of the mentally disabled, regulations, which have been under negotiation for two years, have only recently been adopted; and

WHEREAS, the pressure for deinstitutionalization of state facilities for the mentally disabled, as a means for balancing budgets and funding other state projects, has resulted in an increasingly urgent need for community services for which there has never been adequate funding and has resulted in the placement of more deinstitutionalized adults in ACRs without adequate funding for services or oversight; and

WHEREAS, anecdotal reports suggest that living conditions in some of these homes are poor and, in some instances, warehousing in large, facility-like housing has occurred; and

WHEREAS, parents and advocates for the mentally disabled are increasingly concerned that the lack of funding, services and responsibility for the mentally disabled in ACRs

is resulting in (i) potential regression of the health and developmental condition of mentally disabled residents, (ii) potential danger to themselves or others should residents of varying social and cognitive capabilities be housed in close proximity without proper supervision, and (iii) the relative instability of some placements; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Legislative Audit and Review Commission be directed to examine and recommend the best method for providing mental health, mental retardation and substance abuse services to persons residing in adult care residences, including specific recommendations for funding and determination of services.

All agencies of the Commonwealth shall provide assistance to the Joint Legislative and Audit Review Commission, upon request.

The Joint Legislative Audit and Review Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix B
Agency Responses

As part of an extensive data validation process, State and local agencies involved in a JLARC evaluation are given the opportunity to comment on an exposure draft of the report. Appropriate technical corrections resulting from written comments have been made in this final draft. Page references in the agency responses relate to the earlier exposure draft and may not correspond to the page numbers in this version.

This appendix contains responses from:

- Department of Social Services
- Department of Mental Health Mental Retardation and Substance Abuse Services
- Department of Medical Assistance Services
- Virginia Association of Community Services Boards

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DEPARTMENT OF SOCIAL SERVICES

Clarence H. Carter
Commissioner

June 4, 1997

Mr. Philip A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Richmond, Virginia 23219

Dear ~~Mr. Leone~~ Phil:

Thank you for the opportunity to review and comment on the exposure draft of your study on "Services for Mentally Disabled Residents of Adult Care Residences." The opportunity to meet with you and members of your staff to present possible technical changes and other ways in which recommendations might be improved was appreciated. The Department's comments are based on the Exposure Draft and our understanding of changes that will be made as a result of the draft review process.

The Department recognizes that some mentally disabled residents in adult care residences (ACRs) do require specialized services. The involvement of "case managers" from local community service boards in services planning and additional training for licensing inspectors would augment resources currently available in ACRs where such services are not now provided. The cost of care for residents receiving these services will increase. If these recommendations are adopted by the legislature for implementation, the costs will have to be passed on to the taxpayers of Virginia for public pay residents

The current regulations for licensing requirements, ACR resident assessment and payments for assisted living became final in January of 1996. They have been implemented for all ACRs and their residents. The department implemented them for the express purpose of improving services, protection and care for residents. Their impact has yet to be fully evaluated.

The consideration of your recommendations for additional services to mentally disabled residents in ACRs should be tempered with the knowledge that there are other resident groups who are physically disabled that may likewise benefit from additional services in these facilities. On page 56, your report points out that, "based on the review of model programs for this report, it appears that most of these programs require

funding in excess of the amounts typically available from the auxiliary grant (AG)." Any consideration of improved services for the mentally disabled must take into account the apparent funding disparity that already exists and the needs of other residents.

Responses to Individual Recommendations:

The following comments respond to individual recommendations in the report which would, if implemented, have an impact on this department's current regulations, operational policies or budget:

Recommendation (3).

The department has agreed to development of a curriculum and comprehensive training program for all persons who administer the uniform assessment instrument (UAI). This training program will improve the consistency of assessments and therefore the uniformity of findings and the validity of data that is being collected. A curriculum is currently under development and the program will be implemented in the fourth quarter of this calendar year.

The Commissioner of Social services is a member of a coordinating committee established by the Secretary of Health and Human Resources to improve coordination and collaboration in the provision of services for long term care. Other agencies include the Departments of Aging; Health; Medical Assistance Services; Mental Health, Mental Retardation and Substance Abuse Services and Rehabilitative Services. This committee is leading the development of the UAI training. It could also be asked to examine any limitations inherent in the UAI as a tool for assessing the needs for the mentally disabled.

Recommendation (6).

The Department of Social Services currently has authority in Code of Virginia, § 63.1-179.1, to impose intermediate sanctions, such as fiscal penalties. There have been few attempts to use such sanctions and the Department has never approached the court to impose a fiscal penalty. When attempted, intermediate sanctions were not useful tools because the appeals available to providers are expensive and time consuming. They are the same as those for denial or revocation and halt the imposition of any sanction during the appeal process. Negotiated compliance agreements have generally proved to be more effective. Some have included strategies that might be considered intermediate sanctions, such as requirements for additional staff training or reduced residence capacity during a period of corrective action.

Recommendation (7):

The Department's comments regarding Recommendation (6) apply here, with respect to the use of financial penalties. This recommendation suggests new and expanded training initiatives that would have a significant cost.

Recommendation (10):

The Department supports all reasonable efforts to limit ACR residents' access to street drugs and further to provide services for substance abusers. However, ACR residents are not restricted in their daily activities, for the most part, to the grounds of the ACR. They can come and go as they please for short periods of time.

Recommendation (12):

The Department implemented new licensing and assessment regulations in January 1996. The regulations will be reviewed again, as required by the Administrative Process Act, in 1998. At that time the department can more clearly define the differences in services to residents between residential living, assisted living and intensive assisted living.

Recommendation (13):

The Department agrees that some violations of licensing standards pose more immediate, rather than cumulative risks and should therefore be viewed as more urgent. It is also agreed that intermediate sanctions could perhaps be effective tools if the process for appeals were streamlined. However, the Department also believes that the severity of a violation must be judged in context and flexibility must be retained by the Department to determine how best to achieve protection and compliance with a case by case consideration of circumstances. The Department does not favor trying to develop a list of violations with "automatic" responses attached to particular standards.

Recommendation (15):

The Department of Social Services supports the concept of uniform "core" licensing standards for ACRs. The value of "combined expertise" in the formulation of such standards is acknowledged. The department currently has an advisory committee for ACR activities. It includes representation from provider groups, other state agencies, advocates and staff. The current standards were dealt with extensively in this group prior to their final adoption by the State Board of Social Services. There is

also a subcommittee dealing with revision of cost report and financial data requirements for providers. Another subcommittee could be established to work with leadership from the Department of Mental Health, Mental Retardation and Substance Abuse Services to develop the recommended standards that would supplement "core" standards for ACRs. That department already has the authority to promulgate such standards and to license programs such as substance abuse treatment, etc.

Recommendation (16):

The department agrees that the current cost report system needs revision. Staffs have been working with the advisory committee, referenced above, to achieve such changes. This year for example, providers submitting cost reports for 1996, were required to submit copies of their tax returns or other independent financial statements that would validate data provided in their 1996 cost reports. This change was made with the support of the advisory committee. Other changes will be made. However, this department must continue to gather financial data from providers for the following purposes:

- Validation of budget requests, submitted to the Department of Planning and Budget and the Governor, for increases in the AG rate.

- Monitoring, to assure that payments being made for assisted living services are being used for that purpose.

Recommendation (17):

The Department of Medical Assistance Services (DMAS) is participating with this department in the review of our current cost reporting methodology. This department is cooperating with them in their study of assisted living costs. The department will continue to support DMAS effort.

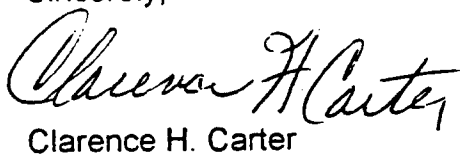
Recommendation (20):

The Department of Social Services can conduct a review of the typical costs incurred by an ACR resident and consider the cost of dental and eye care. Most residents in ACRs who receive AG payments are Medicaid eligible, however, dental and eye care could not be provided only to this one population group. Provision of such services would have to be uniformly available to all Medicaid eligible persons in the same group. If the personal care allowance of the resident was increased to cover

such services, the allowance would have to be paid to the resident who might choose to use the funds for another purpose. The only available option to provide for such costs would be to promulgate regulations that would allow them to be deducted from countable income used to determine eligibility for AG.

Thank you for the opportunity to comment on the exposure draft of this report. We will be glad to provide any additional information, to the Commission, that may be required for their deliberations. Likewise we will move timely to implement those recommendations that are adopted by the General Assembly and enacted as law.

Sincerely,



Clarence H. Carter
Commissioner

CHC/RCG/jw

JLARC Note:

The Department of Social Services reference to Recommendation 20 is to the Exposure Draft. The recommendation in this draft (now Recommendation 22) has been modified based on comments from the Department of Social Services and the Department of Medical Assistance Services.

COMMONWEALTH of VIRGINIA

DEPARTMENT OF

Mental Health, Mental Retardation and Substance Abuse Services

TIMOTHY A. KELLY, Ph. D.
COMMISSIONER

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June 4, 1997

Philip A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Richmond, Virginia 23219

Dear Mr. Leone:

Thank you for the opportunity to review the JLARC study report, Services for Mentally Disabled Residents of Adult Care Residences. The report clearly describes a number of important issues faced by residents of Adult Care Residences (ACRs) who have mental health, mental retardation, or substance abuse problems. This letter will provide you with our Department's initial response to the report's recommendations.

We agree with the report's recommendations regarding improving communication and collaboration between community services boards (CSBs) and ACRs, ensuring adequate service planning and service delivery through training and direct interventions by CSB staff in ACRs, and targeting resources to those communities most in need. Last year, with the State Mental Health, Mental Retardation and Substance Abuse Services Board, we updated and revised our policy, "Placement of Patients and Residents in Adult Care Residences," in support of periodic technical assistance, consultation, and training by CSB and facility staff to staff of ACRs serving their clients and to establish and maintain collaborative working relationships to ensure that consumers receive appropriate services.

We also agree to continue to work with the Department of Social Services and the Department of Medical Assistance Services to develop, refine and implement policies and procedures to further improve services provided to persons with mental disabilities in ACRs, particularly as regards issues of CSB staff access to ACR residents, standards of care for substance abuse services, and practitioner self referral problems.

We do not agree, however, with the recommended module approach to monitoring specific services for specific populations. We have not found the team approach to licensing, as found in the children's residential (CORE) standards, to be very workable. In actual practice,

only each "lead" agency applies its own module. Questions regarding which agency in the team should respond to complaints, whether the module or the regulations take precedence, and how to manage the additional coordination and staffing required remain unresolved.

The chapter in the report on "Best Methods of Providing Services" was both informative and encouraging. We are particularly pleased that the report noted the importance of other community based services, such as psychosocial rehabilitation, employment programs, and Programs for Assertive Community Treatment (PACT). The services provided within the ACR, no matter how excellent and comprehensive, can never adequately provide for inclusive community living without the complement of other supports outside the home.

We have recently awarded $500,000 in funds provided by the General Assembly to District 19 CSB in Petersburg (noted in the report as one of the top five communities with the highest number of auxiliary grant recipients) to develop a PACT program in that area. We are confident that this new PACT demonstration will prove to be a replicable model of "best practice" services to persons with serious mental illness.

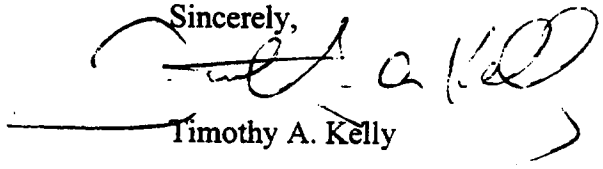
Finally, while recognizing that the JLARC study was focused on examining and recommending the best method for providing mental health, mental retardation and substance abuse service to persons in ACRs, the question of whether the ACR is the best method of providing supportive housing to such persons remains unanswered. Implementing the recommendations in the report will certainly provide for incremental improvements in the ACR model of care, but the problems inherent in institutional oriented programs may persist.

The report noted that the number of ACR beds grew by 5,000 from 1990 to 1997 and the number of Auxiliary Grant recipients rose by almost 1,200. In contrast, discharges from our state facilities to ACRs decreased from 773 to 508 between 1992 and 1996. The vast majority of persons discharged from our state facilities return to their family's or their own home, and for only a relatively small number would facility or CSB staff recommend ACR living if other alternatives were available.

Last year, in a report entitled "The Status and Needs of Virginia's Mental Health, Mental Retardation and Substance Abuse Residential Services," we reviewed the need for additional housing for current CSB clients, especially in regular, non-congregate type homes where supports would be brought to residents based on their individual needs. We are extremely grateful for the General Assembly's recent allocation of $2 million for residential services and for Medicaid SPO services, which have been expanded to include community based supports for persons with mental illness or mental retardation, which will help address these very needs. We believe that our newer models of housing with supports provide much more effective, individualized care than can be found in ACRs for most persons with mental disabilities.

We look forward to continuing to work with JLARC in addressing these and other needs of Virginians with mental disabilities.

Sincerely,



Timothy A. Kelly

TAK/ms

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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June 4, 1997

Philip A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 1100
General Assembly Building
Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

This is in response to your letter of May 23, 1997 soliciting comments to the exposure draft of the JLARC report, Services for Mentally Disabled Residents of Adult Care Residences. Thank you for the opportunity to comment of this draft. I will respond to the recommendations that could affect the Department of Medical Assistance Services (DMAS) in the order in which they appeared in the report.

Recommendation (1). The Department of Medical Assistance Services should more fully utilize Uniform Assessment Instrument data by summarizing, analyzing, and sharing it with the local agencies which helped to collect it, and with other service providers.

DMAS Response: DMAS would need to know specifically what kind of data are being requested and in what format. Before any data could be released in other than a high level summary format, DMAS would need to have assurances that release of the data was directly related to the administration of the Medicaid program. Without these assurance, data could not be released. Compiling and analyzing summary data would possibly require systems development and would surely require the development of SAS runs. This would require additional funds to cover contract costs. This information could not be tailored for specific needs of local agencies without dedicating one or more individuals to this project, depending of the complexity of the analysis that is requested. This would require additional staff resources at DMAS and, since this project would not be for the

administration of the Medicaid program, these individuals would need to be funded totally with general funds.

Recommendation (16). The General Assembly may wish to abolish the rate setting process and cost reporting forms used to set monthly auxiliary grant rates for individual adult care residences. Instead, the Department of Social Services should recommend an appropriate rate annually in the State budget.

DMAS Response: DMAS recommends that DMAS and the Department of Social Services jointly develop financial reporting requirements for ACRs for rate setting purposes.

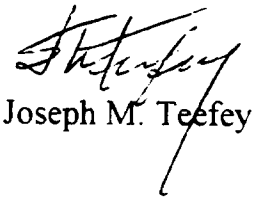
Recommendation (18). The General Assembly may wish to consider amending the Code of Virginia to authorize Department of Medical Assistance Services to reduce, withhold, or suspend assisted living and intensive assisted living payments to ACRs with provisional licenses.

DMAS Response: We agree with this recommendation.

Recommendation (20): The Department of Medical Assistance Services should consider amending the State Medicaid plan to eliminate co-payments for Medicaid funded services for public pay adult care residents.

DMAS Response: The same amount, duration and scope of services must be applied to all categorically needy individuals. The only exceptions are children, pregnant women and institutional individuals in nursing facilities or medical institutions. This does not include Auxiliary Grant recipients. This would have a significant impact on the Medicaid budget.

Sincerely,



Joseph M. Teefey

JLARC Note:

The Department of Medical Assistance Services references to Recommendations 16 and 20 are to the Exposure Draft. The recommendations in this draft (now Recommendations 18 and 22) have been modified based on comments from the Department of Social Services and the Department of Medical Assistance Services.

VIRGINIA
ASSOCIATION
OF COMMUNITY
SERVICES BOARDS, INC.

Mental Health, Mental Retardation, and Substance Abuse Services

Providing Quality Care in Virginia's Communities

June 6, 1997

Mr. Philip A. Leone, Director
JLARC
General Assembly Building, Suite 1100
Richmond, Virginia 23219

Dear Mr. Leone,

On behalf of the entire Association, I congratulate you and your staff on a truly excellent report. The research and resulting exposure draft very insightfully cut to the issues in a balanced, highly focused manner. JLARC is well-known for its fine work, and this document points well to the high standards you uphold as well as to the dedication and commitment of your staff.

The VACSB is greatly appreciative of the opportunity to review and comment on the exposure draft. Our reviewers for the Association were Lundi Martin, executive director of the Richmond Behavioral Health Authority, William Claiborn, Ph.D., executive director of the Alexandria CSB, Hunter Widener, executive director of the Highlands CSB, and Mary Ann Bergeron, executive director of the VACSB. Both Richmond and the Highlands areas contain large concentrations of Adult Care Residences (ACRs). Alexandria also contains ACRs, one of which is operated by the CSB. We felt these perspectives contributed to the review.

It is our belief that the last two sentences in the second paragraph on Page 2 set out the public policy issue for the entire report and the very thorough investigation evidenced in the draft document offers some solutions to the issue.

The Association's major points deal with the solutions that involve adequate funding for basic residential and special needs for individuals with mental disabilities, vigorous enforcement of licensing regulations, and clear public policy direction for all entities involved in the care and treatment of people with mental disabilities. We respectfully offer the specific comments which follow.

On Page 8, we recommend that a table should be added that will show clearly the distribution of beds in ACRs. We believe knowing the distribution of beds in the homes as well as the average capacity is necessary to more fully understand the issues for and about ACRs in Virginia.

On Page 37, under Increased Standards for Dementia, we recommend that consideration be given to establishing ratios for care. Adequate supervision is better addressed in ratios rather than staffing

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numbers overall. If minimum standards are considered, then the size of the ACR should be considered.

On Pages 40-42, placement policies are discussed and improved services, consistent monitoring and better communication are recommended. It is our experience that problems with placement policies occur as result of high demand for placement, economic incentives for ACRs to keep beds full, inadequate enforcement of licensing regulations, and insufficient funding for mental health, mental retardation and substance abuse services. The problem of inappropriate placement needs to be addressed in light of these factors. A clear policy role for DMHMRSAS and fiscal support for CSBs to provide services are needed.

Recommendations (7) (P.51) and (8) (P.55) would be greatly enhanced by addressing the need for increased fiscal support to pay for the care people in ACRs need. For instance, in Southwest Virginia, ACRs continue to receive referrals from Tennessee and Kentucky. Tennessee does not have an Auxiliary Grant program so many individuals placed are referred because of the Auxiliary Grant program and available ACR beds. Despite licensing standards, placement is often based on bed availability, not the individual's needs or preferences. Referral sources have no incentive to coordinate placements through the CSBs and there is no corresponding increase in available resources for the CSB to pay for the special needs of clients with mental disabilities.

In Recommendation (11) on page 63, we suggest, rather than a threshold number of clients with mental disabilities, a staff-client ratio and that the state would fund CSB positions based on these ratios.

On Page 82, use of the Medicaid Waiver and other Medicaid services are discussed. The MR Waiver can be a useful mechanism to support care for ACR residents with mental retardation and the Auxiliary Grant is insufficient to cover more than general supervision. Maximum use of the Waiver can occur only if the expectations for the level of services included in the Auxiliary Grant are minimal and clearly defined, allowing the Waiver to cover all supplemental services. For example, if the minimum staffing ratio was defined for general supervision, staffing above this ratio for resident active care could be paid by the Waiver.

Also, while we agree wholeheartedly that the use of Medicaid has resulted in an excellent expansion, it has been possible because CSBs have had to convert their appropriated State General Funds to act as match for the federal dollars, severely diminishing the ability of CSBs to serve those severely disabled, non-Medicaid eligible individuals.

Page 97 contains a table that acknowledges the cost of quality care for individuals with mental disabilities in ACRs. We urge that a recommendation be developed regarding how funding should be provided for the cost of quality care.

On Page 101 in the second paragraph, just before the last sentence in the paragraph, we suggest that the following clarification be added: "The CSB where the individual is placed receives no fiscal support for providing for the special needs of the individual."

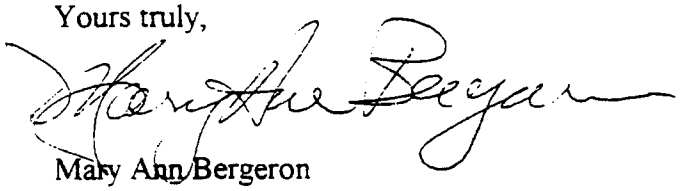
Page 103 concludes a discussion about which our Association has a great deal of concern and would welcome a recommendation. Part of the solution may be funding CSB positions based on the ratio of individuals with mentally disabilities in an ACR.

Pages 110-111 involve a discussion of the need for utilization review. While that may be necessary to evidence that the cost of basic care is not sufficient, we recommend that, rather than merely auditing the money for assisted living, Virginia acknowledge that there is insufficient money to fund basic care, much less specialized services, and make a commitment to resolve the problem. Utilization review does not address the issue of funding basic services.

Building on the above comment, we suggest that Recommendation (17) consider that basic care is not funded to the degree necessary, so before any further demands or standards are placed on ACRs, basic care must be addressed first.

Again, thank you for your fine work. It has been a pleasure to be part of the development process. We are ready to assist in any way we can and look forward to working with you and your staff.

Yours truly,



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